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PROCESS THEORY: A RELIABILITY AND VALIDITY STUDY

by

Barbara Pritchard Nash

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Doctor of Education
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Western Michigan University
Kalamazoo, Michigan
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PROCESS THEORY: A RELIABILITY AND VALIDITY STUDY

Barbara Pritchard Nash, Ed. D.

Western Michigan University, 1984

Process Theory is a new personality/diagnostic system designed by Dr. Taibi Kahler. It is described in detail and compared to other such systems in the psychological literature. A study was conducted to determine the system's interdiagnostician reliability, inter-measure reliability, external validity, and convergent validity with Millon's Clinical Multiaxial Inventory (MCMI). Forty subjects, 20 normal and 20 clinical, were interviewed on tape. The tapes were assessed by three expert diagnosticians. The normal subjects were given the Personality Pattern Inventory (PPI), which is the Process Theory personality test. The clinical subjects were given the MCMI. Interdiagnostician reliability was assessed among the three experts. Inter-measure reliability was measured by comparing the experts' diagnoses to the PPI results. External validity was evaluated by noting the level of functioning assigned to the normal versus clinical subjects. Convergent validity was assessed by comparing the experts' diagnoses to the MCMI results. In all cases, Cohen's Kappa statistic was used to measure agreement. Interdiagnostician reliabilities concerning

agreements as to personality type, and type and phase, were not acceptable. When reliabilities among the judges included agreement that a certain personality type was present in the type-phase pair, the statistics reached acceptable levels. Likewise for reliability across measures: when agreements that a certain type was present were included, reliabilities were acceptable. External validity was clearly demonstrated. The results were significant at the 0.0005 level. Convergent validity with the MCMI was not demonstrated. Implications of this research were discussed and recommendations for future research and the use of Process Theory were made.

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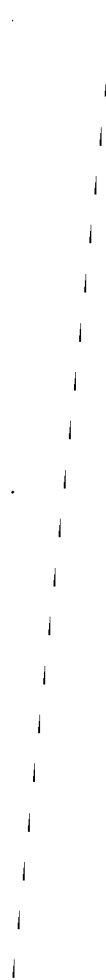
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For it is the mark of an educated man
to look for precision in each class of
things just so far as the nature of
the subject admits.

Aristotle, *The Nicomachean Ethics*, 347 B.C.

For psychiatric diagnosis is at present
sickly, and if this pains us, we can
take some comfort in knowing that our
reaction accurately marks the flawed
nature of our knowledge.

Stoller, *Psychoanalytic Diagnosis*, 1977

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Barbara Pritchard Nash

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CHAPTER I

INTRODUCTION

Background

There is unanimous agreement in the psychological and psychiatric literature that a good diagnostic system is necessary. The monumental work which is the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) (American Psychiatric Association, 1980), the international manual for clinical classification and in itself a testimony to the importance of the concept, identifies the problem: "Over the last decade there has been a growing recognition of the importance of diagnosis for both clinical practice and research" (p. 1). If the psychological profession aspires to being a science, an accurate system for diagnosis is a prerequisite (Skinner, 1981). Grinker (1977) concludes, "In my opinion diagnosis is one of the most important issues confronting modern psychiatry . . . Why make a diagnosis? . . . The answer is that without diagnoses or categories or typologies we have no science" (pp. 69 & 73).¹

¹ The terms psychiatry and psychology will both be used to refer to fields of inquiry related to personality and diagnostic systems.

The reasons why such a system is essential are that they involve furnishing a guide for focusing upon relevant data, providing the necessary prerequisites for useful research, facilitating appropriate treatment, and improving the quality of the training of therapists.

Human thoughts, feelings and behaviors appear amorphous, chaotic and infinitely variable. A system to guide our attention, to help us focus upon the most significant facts and patterns, and to suggest which data to select out of the chaos is needed. Theodore Millon (1981) discusses this point.

There are several benefits that derive from systematizing knowledge in a theoretically anchored fashion. For example, given the countless ways in which the complex of clinical behaviors can be observed and analyzed, a system of explanatory propositions becomes an extremely useful guide and focus. Thus, rather than shifting from one aspect of behavior to another, according to momentary impressions of importance, the clinician is led to pursue only those aspects that are likely to prove fruitful and clinically relevant. Another major value of a theoretical system is that it enables researchers to generate hypotheses about relationships that have not been observed before. . . . In this way, a theoretical framework may enlarge the scope of knowledge by directing observers to potentially significant clinical relationships and constellations. More commonplace, yet significant, is that a theory may enable the clinician to tie new and old observations into an orderly and coherent pattern. (p. 57)

Research is essential for the professional progress

of psychology as a science. And accurate, valid and reliable diagnostic categories are essential for good research (Andreasen & Spitzer, 1979; Cloninger, Miller, Wette, Martin & Guze, 1979; Mazure & Gershon, 1979; Pettifor, 1980). Grinker (1977) states, "Naming and classifying, distinguishing and categorizing are essential parts of any clinical or research enterprise" (p. 71). A good system is necessary for the generation of testable hypotheses, especially about the etiologies of mental problems (Andreasen & Spitzer, 1979; Feighner, 1979; Spitzer, Sheehy & Endicott, 1977). It is also necessary in order to accumulate and organize information and to expand our knowledge (Beck, Ward, Mendelson, Mock & Erbaugh, 1962; Brown, 1977; APA, DSM-III, 1980; Feighner, 1979; Grinker, 1977; Turner, 1968). A third benefit is that a coherent system facilitates communication among researchers and the subsequent replication and validation of studies (APA, DSM-III, 1980; Feighner, 1979; Spitzer, Sheehy & Endicott, 1977). Andreasen and Spitzer (1979) say, "For the researcher, communication within the profession and discovering clues as to etiology are purposes of high priority, and these purposes are best served by delineating diagnostic classes which are as specific as possible" (p. 379). For purposes of

efficiency and integration, a label, according to Grinker (1977), becomes a "shorthand implying specific etiology, symptomatology, prognosis and treatment" (p. 71).

In order to know the best treatment to administer to a client, and to evaluate the relative values of the various treatments to psychological problems, an accurate diagnostic system is needed. Strupp (1977) states:

The field can no longer afford the luxury of two people meeting for seemingly interminable periods of time in the hope that regression will somehow bring elusive transference problems into focus and aid the process of "working through." (p. 8)

Grinker (1977), in his inimitably pithy way, says, "The clinician must know what and whom he is treating in order to decide how to treat" (p. 71). It is an undisputed goal of the profession to match the best treatment to each particular problem (Cloninger et al., 1979; Gaensbauer & Lazerwitz, 1979). The better we can understand and describe the problem, the more effective we can be in instituting the appropriate treatments (APA, Brown, 1977; DSM-III, 1980; Feighner, 1979; Kass, Skodol, Buckley & Charles, 1980; McDermott, 1981; Turner, 1968). Regarding the importance of treatment evaluation the DSM-III (APA, 1980) says, "The efficacy of various treatment modalities can be compared only if patient groups are described using diagnostic terms that are clearly defined" (p. 1). (See also Turner, 1968.)

Finally, an accurate diagnostic system is indispensable in the training of psychotherapists. According to Turner (1968), "A higher level of competence can be achieved when treatment is consciously and selectively based on detailed diagnosis of the clients" (p. xviii).

The magnitude of the importance of this issue is attested to by the number and frequency of articles from all over the world on the subject. There is serious and current concern over diagnostic issues not only in Canada (Kelm, 1981) and England (Tyrer & Alexander, 1979), but also in Germany (Sulz-Blume, Sulz & von Cranach, 1979; Witzlack, 1979), the Netherlands (Derksen, 1981), Sweden (Agren, 1979; von Knorring, Perris, Jacobsson & Rosenberg, 1980), Sicily (Ferrauto, Rapisarda, Zappala & Marceno, 1979), and Spain (Sanchez-Turet, Vallejo-Ruiloba, Porta & Cuadras, 1981). This interest is not limited to the free world. It is also shared by countries behind the iron curtain, such as Poland (Jarosz, 1981; Stanikowska, 1981), Czechoslovakia (Krivulka, 1979), Rumania (Grigoroiu-Serbanescu, 1981), the German Democratic Republic (Liesk, 1981), and the Soviet Union itself (Gerasimov, 1980; Grigor'yeva, 1979; Milyavskiy, 1981).

There is little disagreement that a diagnostic system

is vital to psychology. As Feighner (1979) says, "It is extremely important that nosology and phenomenology be systematically approached, with rigorous attention to detail and without theoretical prejudice" (p. 1173).

Yet, if we proceed on the assumption that we need a good diagnostic system, the next logical question becomes, "Do we have one?" The following discussion suggests that the answer is "No." In 1968, Turner said:

It is clear that we do not have the last word in typologies of clients and the significant variables which must be assessed for effective treatment. Similarly, systems we presently use are far from perfect and complete. It is inevitable that most of them will be replaced as better understanding is achieved. (p. xxii)

Things had not improved by 1973 when Meehl wrote:

How do I help my clients . . . practicing an art that applies to a primitive science? How do I preserve my scientific mental habits and values from attrition by the continual necessity . . . to think, act and decide on the basis of scientifically inadequate evidence - relying willy-nilly on clinical experience, hunches, colleagues' anecdotes, intuition, common sense, far-out extrapolations from the laboratory, folklore, introspection and sheer guesswork? (p. vii)

Nor were they any better in 1977 when Stoller wrote:

For psychiatric diagnosis is at present sickly, and if this pains us, we can take some comfort

in knowing that our reaction accurately marks the flawed nature of our knowledge. . . . Our understanding of the underlying dynamics and of etiologies is meager in many areas of psychiatric diagnosis; it is oppressive to know we do not yet have a consensus about what we shall elevate to the status of syndromes. . . . We should also confess that there is little organization to our diagnostic 'system'. . . . This is not our fault, but it is hard to defend such mucking about. (pp. 26-27)

One might think that currently, with the publication of the DSM-III, things would have improved. But in fact, the most vehement criticism in the literature is the most recent. McDermott (1981) states:

The case for diagnostic congruence within mental health and allied specialties, at best, is very weak, with agreement among professionals either absent or statistically and practically inconsequential. This is true for diagnostic activities among clinical psychiatrists (Sandifer, Hordern, Timbury & Green, 1968; Sandifer, Pettus & Quade, 1964; Spitzer & Fleiss, 1974), pediatric psychiatrists (Freeman, 1971), clinical psychologists (Little & Shneidman, 1959; Zubin, 1967), clinical child psychologists (Achenback & Edelbrock, 1978), mental health agencies (Fiestler & Rudestan, 1975), public mental health employees (Coie, Costanzo & Cox, 1975) . . . [and] school psychologists (McDermott, 1980). . . . The prevailing trends of research findings are discouraging and raise suspicions about the overall integrity of diagnostic practices. . . . [There is an] urgent need for better, more efficient and effective means of assessing human lives. (pp. 33-34)

There have been numerous articles in the literature critical of the current state of affairs in diagnosis (Crown, 1975; Farber, 1975; Millon, 1975; Millon, Green &

Meagher, 1979; Rosenhan, 1973; Skinner, 1981; Spitzer, 1975; Weiner, 1975). The problems can be divided into four major areas: (1) there is little congruence among the various systems in use; (2) there are serious validity problems with the current diagnostic categories; (3) there are major technical problems, and problems with bias; and (4) these all lead to massive misdiagnosis.

Recently some studies have focused on the issue of diagnostic concordance (agreement) among the various major systems in use (Gift, Strauss, Ritzler, Kokes & Harder, 1980; Singerman, Stoltzman, Robins, Helzer & Croughan, 1981; Zisook, Click, Jaffe & Overall, 1980). These findings show that "Not only did criteria sets select different proportions of the total, but they also selected substantially different patients" (Zisook et al., 1980, p. 13). Such results further indicate the need for new directions.

Grave questions have also been raised about the validity of the categories currently in use. They have been criticized for vagueness (Klerman, Endicott, Spitzer & Hirschfeld, 1979), inappropriateness of fit for the client populations (Strauss, Gabriel, Kokes, Ritzler, Van Ord & Tarana, 1979), lack of predictive validity (Williams, 1979; Zisook, Overall & Click, 1981), and, most

importantly of all, construct validity (Sarbin & Mancuso, 1980). In this last regard, Fenton, Mosher and Matthews (1981) go so far as to say:

None of these systems (Schneider's First Rank Symptoms, New Haven Schizophrenia Index, Flexible System, Feighner Criteria, Research Diagnostic Criteria, and DSM-III) has established construct validity. It is noted therefore that they are all, in a sense, arbitrary. (p. 452)

This is a very strong statement. If true, it conceivably invalidates the systems currently in use.

Major technical problems are also important. According to Spitzer, Endicott and Robins (1978), "A crucial problem in psychiatry, affecting clinical work as well as research . . . is the generally low reliability of routine clinical psychiatric diagnostic procedures" (p. 773). The sheer amount of research put into evaluating this problem is testimony to its magnitude (Fenton, Mosher & Matthews, 1981; Freedman, 1979; Grove, Andreason, McDonald-Scott, Keller & Shapiro, 1981; Kass, Skodol, Buckley & Charles, 1980; McDermott, 1981; Mezzich, 1979; Sarbin & Mancuso, 1980).

Another salient variable to consider is the effect of therapist bias upon the diagnosis given. Several studies have shown biasing effects of social class and professional status, sex, race, and other sociocultural

and educational factors (Adebimpe, Gigandet & Harris, 1979; Ferrauto et al., 1979; Sarbin & Mancuso, 1980; Warner, 1979; Wright, Meadow, Abramowitz & Davidson, 1980).

One might well conclude that these problems frequently lead to misdiagnosis of clients. The literature supports this deduction (Freedman, 1979; Holland, 1979; Kass, Skodol, Buckley & Charles, 1980; Kendler & Tsuang, 1980; McDermott, 1981; Sarbin & Mancuso, 1980; Strauss et al., 1979; Toone & Roberts, 1979).

This researcher shares the sentiments of Miller and Magaro (1977) that "the time may be ripe for new, more sophisticated typological theories that combine several personality dimensions into multidimensional personality 'types'" (p. 460). It is just such a theory that this paper proposes to evaluate, that is, the work of Dr. Taibi Kahler (Kahler 1979, 1982a, 1982b, 1982c, & 1982d).

Significance of the Study

Kahler's system might provide a solution to the aforementioned problems. It has certain advantages over systems currently in use. It is consistent with the body

of traditional psychodiagnostic literature, but it improves upon it by organizing personality types into discrete, mutually exclusive categories and expanding the concepts to include high functioning people. There are concrete, objective cues used in assessing personality type (the term "diagnosing" is only warranted if relevant negative behaviors are present), and the theory provides testable hypotheses about how people will develop under optimal conditions, how they will deteriorate under poor conditions, the best therapeutic techniques to use, and so forth. Because of the wealth of information conveyed by each diagnosis (etiology, family background, therapeutic and relationship issues, etc.), the categories provide an efficient shorthand for communicating information.

But the first step in evaluating a diagnostic system is to evaluate its reliability and validity. That evaluation will be conducted in this study.

The four research questions are as follows: (1) Can Process Theory produce acceptable interdiagnostician reliability?; (2) Can Process Theory produce acceptable reliability across measures?; (3) Can external validity be demonstrated?; and (4) Can convergent validity with a proven diagnostic instrument be demonstrated?

Limitations

Three factors will limit the scope of this work. First, the thorough description and evaluation of all diagnostic systems currently in use would constitute a dissertation in itself; therefore, these systems will be described and the important criticisms of the major systems discussed. Second, because of the tightening restrictions upon the use of human subjects for research and even more so upon the use of confidential clinical material outside the treating organization, availability of subjects will be limited. Therefore a modest sample size will have to suffice. Lastly, since this system is so new, expert diagnosticians are few and far between. The design will have to make do with three judges. Still, an adequate evaluation may be done within these parameters. The further evaluation of this theory, one hopes, can build upon the foundations established here.

Summary

To conclude, the psychology profession must have a solid and workable diagnostic system in order to function well and to progress as a science. The systems currently in use have serious and debilitating problems. Therefore this study will evaluate a new system that might replace and improve upon current ones.

CHAPTER II

REVIEW OF RELATED LITERATURE

Definition of Terms

Before proceeding, some terms must be defined. Webster's Third New International Dictionary defines personality as "the complex of traits or characteristics that distinguishes a particular individual. . . .the organization of the individual's distinguishing character traits, attitudes and habits" (p. 1687). Millon (1981) adds to this definition: personality involves "preferred ways of relating to others and coping with this world. . . . [A] pattern of traits. . . .[I]ngrained and habitual ways of psychological functioning . . . a tightly knit organization of attitudes, habits and emotions" (p. 4). The concept of "character" is so closely related that it will be used synonymously. "Psycho-diagnostic systems" or "nosologies" or "personality typologies" are ways of categorizing individuals based upon the salient and most important characteristics of their personalities. Each of these terms has a slightly different connotation. The first two imply psychopathology; the last does not. There is no term that truly suffices for both healthy

and pathological conditions. This problem in terminology mirrors a problem in epistemology; there are few, if any, typologies that encompass both healthy and pathological personalities. Since the system to be evaluated in this study does encompass both conditions, all of these terms are relevant and will be used in subsequent discussions, depending upon the aspect under consideration.

Personality Typologies from Ancient Times
to the Present

Since ancient times people have sought to classify and understand human personality (Allport, 1937; Millon, 1981; Roback, 1927).² Beginning in the fourth century B.C., Aristotle and Theophrastus delineated certain dominant personality traits and then used them as cornerstones in developing a classification scheme of personality types. It was also during that time that the theory of the four humors was developed by Hippocrates in order to explain physical disease as well as personality style. The four humors were yellow bile, black bile,

² For a thorough and scholarly treatment of this subject, see Millon, 1981.

blood and phlegm; the temperaments that corresponded to an excess of these humors were, respectively, choleric, melancholic, sanguine and phlegmatic. In the second century A.D., the physician Galen further elaborated these into personality styles characterized by contentiousness, melancholy, confident optimism and stolidity. In another vein, there were those, beginning again with Aristotle, who sought to discover truths about temperament and character from outward appearance using such things as facial features and head contours.

During the middle ages the investigations into temperament, and even more so into personal eccentricities, became more ecclesiastical than scientific. The Malleus Maleficarum, circa 1486, (Kramer and Sprenger, 1971) was considered the "ultimate, irrefutable, unarguable authority" on witchcraft and "possession" (which were the explanations most commonly given for emotional problems) (p. viii). In it, Kramer and Sprenger (1928/1971) stated:

The devil can also essentially possess a man, as is clear in the case of frantic men. . . . Now it would be a miracle if anyone in this life could thoroughly explain in what and in how many ways the devil possesses or injures men. . . . For some are affected . . . in their inner perceptions; some are so punished as to be at times only deprived of their reason; and others are turned into the semblance of irrational beasts. (p. 129)

This was an era of dogma, and since dogmatism at least stifles and at most kills the spirit of objective inquiry, systematic investigation ceased. The situation did not improve for another two centuries or so.

Lowry (1971) states:

In the sixteenth century it was quite unthinkable that there remained anything further to be learned about human nature. . . . The limits of mere mortal understanding on this important subject had, so it was thought, already been reached; accordingly, what was unknown was considered destined forever to remain so. And yet, by contrast, it was scarcely a century later that men began to inquire into human nature with an optimism and systematic thoroughness unrivaled even by the ancient Greeks. . . . Psychology had broken free from its traditional role of ancilla theologiae - the handmaid of theology - and was now beginning to follow the lead of a different mistress. (pp. 3-4)

It seems that it took nearly twelve centuries for systematic inquiry into personality to get back to where it had begun. In fact, Descartes (1649) thought the situation even worse than this:

There is nothing in which the defective nature of the sciences which we have received from the ancients appears more clearly than in what they have written on the passions . . . [what they] have taught regarding them is both so slight, and for the most part so far from credible that I am unable to entertain any hope of approximating to the truth except by shunning the paths which they have followed. This is why I shall be here obliged to write just as though I were treating of a matter which no one had ever touched on before me. (p. 149)

In spite of the contagion of optimism at the outset of this new age, nothing of significance in the area of personality typologies was produced until the twentieth century. Descartes, Thomas Hobbes, John Locke and the other creative minds of the time spent their energies more upon philosophical speculations as to the nature of man than upon delineations of characterological typologies. The field had to wait another few hundred years for the likes of Ribot (1890) and Queyrat (1896) to begin again the process of developing systems for categorizing the human personality. Even so, these first simple attempts and those of the others that followed closely thereafter (Heymans & Wiersma, 1906-1909; Hirt, 1902; Kollartis, 1912; Lazursky, 1906; McDougall, 1908; Meuman, 1910) did not go very far. They produced a few simple typologies which have since sunk into oblivion.

There were two outstanding nosologists at the turn of the century, the impact of whose work has lasted: Emil Kraepelin (1887, 1896, 1899, 1909-1915, 1913, 1921) and Eugen Bleuler (1906, 1911/1950, 1924, 1929). Unfortunately their focus was solely on psychopathology. They investigated morbid and pre-morbid personalities (Kraepelin, 1913) which related to problems of manic

depression, autism and criminality. So, although they gave us a great deal of insight into pathological processes and syndromes, their work was not very enlightening as regards normal personality processes. The same was true of the later theorists Schneider (1950), Sullivan (1947) and Walton (Walton, Foulds, Littman & Presley, 1970; Walton & Presley 1973a, 1973b), and it is obvious from the names of the categories they used:

Schneider: hyperthymic, depressive, insecure, sensitive, compulsive, fanatic, attention-seeking, labile, explosive, affectionless, asthenic. (1950)

Sullivan: non-integrative, self-absorbed, incorrigible, negativistic, ambition-ridden, asocial, inadequate, homosexual, chronically adolescent. (1947)

Walton et al.: character disorders (withdrawn, dependent, over-assertive), personality disorders (schizoid, hysterical, paranoid, cyclothymic, obsessional), sociopaths. (1970) (Cited in Millon, 1981, pp. 42-45.)

There have been some attempts at constructing systems that include normal as well as abnormal personalities, specifically the work of Adler (1964), Cattell (1954, 1957, 1965), Eysenck (1952, 1960, 1967, 1970), Eysenck and Eysenck (1969, 1975, 1976), and Jung (1921/1971). Millon (1981) points out the problems with each of these attempts. About Cattell he says, "The traits that cluster factorially in his work neither consolidate into

clinically relevant syndromes nor generate enough variety to comprise a comprehensive classification" (p. 41). About Eysenck he says, "[His] formulations provide us with a rather skimpy range of clinically diverse personality types" (p. 41). Similarly, "Jung's typology has but limited utility to the understanding of patients since it reflects his theoretical speculations about the essence of personality structure and not the problems of everyday clinical practice" (p. 52). Adler's formulations share the same drawbacks, according to Millon (1981).

No history of personality typologies, however brief, would be complete without mention of the psychoanalytic theorists' contributions. The work of Abraham (1921, 1924, 1925), Freud (1896, 1908, 1932), Reich (1949), and later Kernberg (1967, 1975, 1980) on the oral, anal, phallic and genital character types forms a major part of the literature on personality. Critics would say that the drawbacks of this system relate to the hypothesized origins of these types. They are all supposed to be compensations for or reactions to early childhood traumata or severe insoluble conflicts. Hence, as with many of the previous typologies, they are strongly oriented toward pathology and may be of little help in explaining healthy personality processes, not to mention personal growth.

Unfortunately, the same may be said of the interpersonally oriented theories of Horney (1937, 1939, 1942, 1945, 1950) and Fromm (1947). Horney's three personality types (compliant, aggressive and detached) are all neurotic. And of Fromm's five types (receptive, exploitive, hoarding, marketing and productive), only one is healthy and creative.

In sum, one might be encouraged by the efforts and enthusiasm put into constructing personality typologies even though one may be discouraged by the apparently flawed nature of the results thus far. Millon (1981) says:

What should be especially heartening is that theorists and classifiers have been convinced that the complexities . . . of human personality can . . . be studied systematically and will, it is hoped, yield to our efforts at scientific comprehension. . . . [It is important] to construct a consistent framework that will create order and give coherence to the broad spectrum of mental disorders. A review of the theorists . . . indicates that many have pursued this goal, but few, if any, have succeeded in formulating as comprehensive and integrated a framework as is necessary to encompass even the personality disorders. (pp. 24 & 57)

Contemporary Diagnostic Techniques

Fortunately or unfortunately in the field of psychology it is often the case that, while theories may be vague, inconsistent and not generally agreed upon,

related techniques may at the same time be useful, precise and scientifically sound. So it is, for example, with intelligence and the IQ tests. Psychologists often disagree about definitions of intelligence, but the IQ tests are some of the most useful instruments the profession has. With this in mind, let us leave the morass of theory for the moment and examine the diagnostic techniques that are currently in use.

The diagnostic techniques that are currently in use can be divided into four groups for the purposes of this discussion. First, there are those that are so obscure or so esoteric that they are of limited value, and thus will be mentioned but not discussed at length. Then, in order of increasing importance, there are the computerized systems, the projective techniques and the major, widely used systems.

The lesser known or seldom used diagnostic techniques are judged by this researcher to be so if they were mentioned only once or twice in the literature during the past five years. There are a number of techniques from foreign countries that fall into this category: the Arbeitsgemeinschaft für Methodik und Dokumentation in der Psychiatrie from Germany (Sulz-Blume, Sulz & von Cranach, 1979), a personality inventory from Rumania

(Grigoroiu-Serbanescu, 1981), the Pracoxgefühl from Poland (Jarosz, 1981), and a technique using poetry to diagnose schizophrenia from the USSR (Milyavskiy, 1981). There are some references from other countries using tests of American origin: the Multi-aspects Classification of Mental Disorders was studied once in Sweden (von Knorring, Perris, Jacobson & Rosenberg, 1980); Epstein's and Payn's tests were studied in Poland (Stanikowska, 1981); the Multi-axial Classification Model and the ICD-8 were used in Sicily (Ferrauto, Rapisarda, Zappala & Marceno, 1979); the Hoffer-Osmond Diagnostic Test was studied in Canada (Kelm, 1981); and Leary's Diagnostic Test was used in Czechoslovakia (Krivulka, 1979). And there are a few esoteric techniques that use such things as proverbs (Reich, 1981), art productions (Russell-Lacy, Robinson, Benson & Cranage, 1979), voice tone (Leff & Abberton, 1981), and social interactions (Rosen, Tureff, Daruna, Johnson, Lyons & Davis, 1980) in the service of differential diagnosis.

Then there are the myriad of diagnostic techniques which for one reason or another have not been widely used or were rarely mentioned in recent literature. These include the Maine Scale and the Weighted Symptom-Sign Inventory (Magaro, Abrams & Cantrell, 1981), the

Diagnostic Interview Schedule (1980), the Schedule for Schizotypal Personalities (Baron, Asnis & Gruen, 1981), the Twelve Point Flexible Diagnostic System (Carpenter, Strauss & Bartko, 1981), the Biplot (Strauss, Gabriel, Kokes, Ritzler, Van Ord & Tarana, 1979), the Winokur criteria and the ICD-9 (Kendler & Tsuang, 1980), Schneider's First Rank Symptoms and the New Haven Schizophrenia Index (Fenton, Mosher & Matthews, 1981), the Multivariate Personality Inventory (Miller & Magaro, 1977), Bleuler's and Kraepelin's criteria (Kendler & Tsuang, 1980), the SLC-90 (Derogatis, Lipman & Corvi, 1973), the SASB (Benjamin, 1974), the Inpatient Multidimensional Psychiatric Scale (Lorr, 1966), the Eysenck Personality Questionnaire (Eysenck & Eysenck, 1975), and the Differential Personality Inventory (Skinner, Jackson & Hoffman, 1974). There are a number of such instruments that do not even have names, but are merely described as "a procedure" or "an interview format" (Aigen, 1980; Cantor, Smith, French & Mezzich, 1980; Gaier & Lee, 1953; Overall, Hollister, Johnson & Pennington, 1966; Rutter, Shaffer & Shepherd, 1975; Stone, 1979; Strauss, 1979; Tyrer & Alexander, 1979). There are others that are infrequently used because they apply only to a single, limited population or diagnostic category.

Examples of these include the St. Louis, New York, and Texas Actuarial and Composite Criteria for depression (Zisook, Overall & Click, 1981), the Diagnostic Classification System for Psychopathological Disorders of Childhood (Acuff, 1981), the Passive Aggressiveness Scale (Soper, 1980), and the Diagnostic Interview for Borderlines (Soloff, 1981; Soloff & Ulrich, 1981). There are even some personality tests that apparently do not merit study or even mention in recent literature, such as the Myers-Briggs Type Indicator (Briggs & Myers, 1976; Myers, 1962), the Edwards Personal Preference Schedule (Edwards, 1953), the California Psychological Inventory (Gough, 1956), the 16 PF (Institute for Personality & Ability Testing, 1956), the Personal Orientation Inventory (Shostrom, 1962) and the FIRO-B and -F tests (Schutz, 1957, 1967). Constraints of time and space, and the scope of this work do not permit evaluation or discussion of these lesser-used diagnostic techniques. Let us therefore proceed to the more widely-used instruments.

Beginning in the late 1960s, psychologists began to explore the use of computers in differential diagnosis. The first attempt was a system called DIAGNO (Spitzer & Endicott, 1968, 1969, 1974; Spitzer, Endicott, Cohen & Fleiss, 1974). Later there was another attempt called

CATEGO (Wing, 1980). Neither turned out to be very helpful. In fact, the inventors themselves realized the limited value of such an approach. Wing (1980) said, "CATEGO is not intended to provide an alternative system of diagnosis to those in common use or to be more than a technical aid in clinical work" (p. 17). Andreasen and Spitzer (1979) went even farther, saying, "Computerized approaches to diagnosis are limited in their applications and not likely to supplant the traditional clinical diagnostic process, even for purposes of research" (p. 384).

Another major category of diagnostic techniques that bears mention is projective tests. There are some infrequently cited tests such as the Draw-A-Person test (Levins, 1981), the Bender-Gestalt (Mermelstein, 1981), and the Thematic Apperception Test (Gittelman, 1980), but the most commonly used projective test by far is the Rorschach (Blumenthal, 1981; Singer & Larson, 1981; Spear, 1978). Despite the frequent use of projective tests in diagnosis, there is reason to believe that they are, to say the least, not very good instruments. There is recent information (Gittelman, 1980) which suggests that such tests are unreliable, that they do not provide clinically meaningful information, and even that they are "not valid

for diagnostic purposes" (p. 413). McDermott (1975) has demonstrated a "direct positive relationship between psychologists' difficulty in reaching diagnostic decisions and reliance on projective test data, as well as between the use of such data and ultimate incongruence among psychologists" (p. 3520-A). And other researchers (Bersoff, 1973; Little & Schneidman, 1959; McDermott, 1981) have asserted that information from projective tests "convolutes decision making and results in unstable and invalid diagnoses" (McDermott, 1981, p. 36).

Emerging from the plethora of seldom used, esoteric or severely problem-ridden diagnostic techniques are a few major systems that are frequently used. Notwithstanding the fact that these may be the best instruments available, each one has debilitating flaws.

The two major structured interview systems, the Schedule of Affective Disorders and Schizophrenia (Endicott & Spitzer, 1978; Rogers, Cavanaugh & Dolmetsch, 1981; Spitzer & Endicott, 1975) and the Present State Examination (Kendell, Everett & Cooper, 1968; Luria & McHugh, 1974; Wing, 1970; Wing, Birley, Cooper, Graham, & Isaacs, 1967; Wing, Cooper & Sartorius, 1974) have been criticized for inadequacy. Luria & Guziec (1981) state, "Neither instrument comprises a complete assessment of the

current mental condition of the patient" (p. 248)--not to mention that they focus only on illness.

The two major systems which use specified criteria and operational definitions, the Feighner Criteria (Feighner, 1979; Feighner, Guze & Robins, 1972; Tsuang, Woolson & Simpson, 1981), and Spitzer's Research Diagnostic Criteria (Agren, 1979; James & May, 1981; Spitzer, Endicott & Robins, 1977, 1978) have been attacked on the most fundamental grounds. Fenton, Mosher, & Matthews (1981) state, "None of these systems, Feighner criteria, Research Diagnostic Criteria . . . has established construct validity. It is noted therefore that they are all, in a sense, arbitrary. Choosing one over another cannot be data based" (p. 452). It is obvious why construct validity is such a problem when we look at the instruments themselves. The Research Diagnostic Criteria (Spitzer, Endicott & Robins, 1978), for example, allows such diagnoses as "depressive syndrome superimposed on residual schizophrenia" (p. 775). And even in the more clear-cut case of manic-depressive psychosis, these authors say, "There is no consensus on how to diagnose this condition, or even whether or not it represents a variant of affective disorder, schizophrenia or a separate condition" (p. 776). To compensate for this

lack of construct validity, they allow multiple diagnoses for the same episode of illness, which, unfortunately, confuses matters further. And here, again, these instruments only diagnose illness. They do not address the strengths or coping mechanisms of the whole personality, other than to have a category labelled "currently not mentally ill."

The Minnesota Multiphasic Personality Inventory (MMPI) (The Psychological Corporation, 1943) is a widely used diagnostic instrument. To do a complete and thorough analysis of it would be a dissertation in itself since there are over 9,000 books and articles on it (Graham, 1977). Suffice it to make a few remarks regarding its shortcomings in terms of the task at hand. Duckworth (1979) states that the MMPI was created in 1943 as a "psychological instrument designed to diagnose mental patients into different categories of neuroses and psychoses" (p. 1). That is, it was not constructed to assess normal, healthy personality processes; it was constructed to diagnose pathology, as the scales themselves attest. But it did not even succeed at that. Duckworth (1979) states, "Designers expected that people taking the test would have an elevation on one scale which would then indicate the diagnosis for that person" (p. 1);

it soon became evident that this expectation was not fulfilled. The test came to be used instead as a descriptive instrument and an aid to gathering additional clinical data on the patients. This may be one of the reasons that research on it slowed down as time went on. In the forward to Graham's book (1977) Butcher describes this trend in MMPI research.

Although considerable gains in the empirical description of abnormal behavior were made in [the late 1950's and early 1960's] recent progress has been disappointing. It is uncertain whether this present lull is asymptotic or simply a resting period. . . . However, it is clear that advances in methodology as well as growth in new knowledge have pretty much ended. . . .short of the promised goal. (p. vii)

An objective sign of this lull is that there were only four research projects published on the diagnostic use of the MMPI during the period encompassed by this literature search (Norman, 1972; Raines, 1980; Skinner, 1979b; Skinner & Jackson, 1978). The disappointment of the original hopes for the MMPI combined with the recent enthusiasm for the DSM-III may explain the dearth of current research.

The DSM-III (APA, 1980) can be seen as a monumental effort to cope with the problems of psychodiagnosis. None- theless, it too has come under criticism. The task

force that revised the manual (Task Force, 1976) stated that the syndromes were "fuzzy at the edges" (cited in Millon, 1981, p. 62). Since then the DSM-III has been criticized for lacking construct validity (Kendler, 1980a, 1980b), for being "excessively intricate and complicated" and for reflecting a "mechanistic Kraeplinean view of behavioral disorders" (Foster, 1978, p. 20), for having inadequate reliability (Mezzich, 1979; Wachtel, 1980), and for not reflecting current advances in knowledge (Nathan, 1979). There is also serious doubt, according to Karasu and Skodol (1980), that it is of any use whatsoever in planning appropriate treatment--which is, or should be, one of the main purposes of psychodiagnosis. Spitzer, Sheehy and Endicott (1977) said, "We recognize that many of the . . . categories in DSM-III have insufficient evidence of predictive validity in the sense of providing useful information for treatment assignment or outcome" (p. 15). And DSM-III itself admits that "for most of the categories the diagnostic criteria . . . have not been fully validated by data about such important correlates as clinical course, outcome, family history and treatment response" (p. 2). DSM-III does not appear to be the panacea everyone hoped it would be.

The same conclusion may be reached here as in the earlier discussion of personality typologies; though the great efforts that have gone into the construction of diagnostic instruments attest to the importance of the task, the results thus far have been far from perfectly satisfying for many psychologists. The point of this review and discussion has been to show that there is still a need for a personality typology/diagnostic system in the field of psychology that is generally acceptable. A description of a system that may achieve this will follow a discussion of some similar theories, a brief review of the current consensus on criteria for such a system and a description of the origins and current conceptualizations of the six personality types which the new theory uses.

The Concept of a Multivariate Personality Typology

Miller and Magaro (1977) said, "The time may be ripe for new, more sophisticated typological theories that combine several personality dimensions into multi-dimensional personality types" (p. 460). They produced a series of studies and papers exploring the concept of a personality typology in which each category could range from pathological to normal (Miller & Magaro, 1975; Miller & Magaro, unpublished; Magaro & Smith, 1981).

Miller and Magaro (1977) state:

This theory suggests that any personality type or style consists of a specific combination of psychological defenses, cognitive and affective styles, belief and value systems, moral development, etc. Members within a specific style may vary in the degree to which these common factors or style are manifested, but all members of one style share the same major characteristics. . . . Each style also includes the entire range of adjustment, from well-adjusted "normal" people to poorly adjusted hospitalized patients. That is no one group is viewed as pathological; rather, each style contains some members typically judged as "abnormal."
(p. 460)

Simultaneously, in England, ideas of a similar nature were emerging. Tyrer and Alexander (1979), using a factor analysis technique, found that "personality disorders differ only in degree from the personalities of other psychiatric patients" (p. 163). And, in fact, the task force working on the DSM-III even considered the notion although they never went very far with it (Task Force, 1976). Millon (1981) states, "An early aspiration of the committee was the differentiation of personality types along the dimension of severity; unfortunately criteria for such distinctions were never developed" (p. 63).

So the idea is current. Major minds in the field actively consider it; but there is no full-blown realization of the concept. Miller and Magaro

(unpublished) found evidence for three such styles--hysteric, obsessive-compulsive, and sociopathic--but they never developed their findings into a complete system. Other theorists, whose conceptions will now be discussed, did develop more complete typological systems, but did not include the whole range from pathological to normal. The gap remains.

Criteria for a Personality/Diagnostic Theory

A discussion of the relevant criteria for a personality/diagnostic system is in order. For a start, the categories must be reliable and valid. There is general agreement on the necessity of adequate reliability (Andreasen, Grove, Shapiro, Keller, Hirschfeld & McDonald-Scott, 1981; Andreasen & Spitzer, 1979; Cantwell, 1980; Cloninger et al., 1979; APA, DSM-III, 1980; Feighner, 1979; Grove et al., 1981; Haier, 1980; McDermott, 1981; Ward, Beck & Mendelson, 1962). Skinner (1981) defines reliability as:

The extent to which patients possessing similar attributes will be assigned to the same diagnostic category. A reliable classification system should be consistent from user to user (interdiagnostician agreement) and within the same user over different time periods (inradiagnostician consistency). (p. 69)

The trouble is that it is difficult to determine acceptable levels of reliability. Grove et al. (1981) said, "No useful statistical test is available to determine when reliability is acceptable . . . investigators often make the simple assumption that a K [Kappa] value of more than 0.5 or 0.6 is acceptable" (p. 412), but this is just a rule of thumb. Yet they believe that even very high reliability is insufficient. Grove et al. (1981) also said that "diagnosticians conceivably may agree perfectly but be wrong all the time. A reliable measure that has no validity is worthless" (p. 410). So validity is also essential.

Validity is usually mentioned along with reliability as a crucial criterion for evaluating a theory (Cantwell, 1980; APA, DSM-III, 1980; Feighner, 1979). Some, in fact, think it is more important. Andreasen and Spitzer (1979) say that "ultimately any diagnostic system must be evaluated primarily in terms of its usefulness or validity" (p. 385). There are many different kinds of validity. Andreasen and Spitzer (1979) mention four:

Face validity refers to whether or not the various diagnostic categories "make sense" clinically and appear to describe conditions which actually occur. Content validity is assessed by determining whether or not all patients can be classified by the system. Construct validity refers to whether or not

the system is consistent with an underlying theory or construct . . . Criterion-related or predictive validity is perhaps the most important in assessing the value of a diagnostic system. . . . [It] refers to whether or not a particular diagnosis is useful in making predictions about some future behavior, such as a response to treatment, course or prognosis. (p. 385)

Skinner (1981) adds descriptive validity, "the degree to which categories or types within the system are homogeneous with respect to relevant attributes" (p. 69); internal validity (a concept he defines statistically); convergent validity, "the extent to which individuals are classified according to the same type across alternative measures" (p. 77); discriminant validity, "the distinctiveness among types across alternative measures" (p. 77); and external validity, a larger concept which encompasses "prognostic usefulness, descriptive validity, clinical meaningfulness . . . and generalizability" (p. 76). In the final analysis, all of these should be satisfied, according to Skinner.

Besides these objective criteria, there are other elements that a good personality/diagnostic system should have. DSM-III lists some of these, while admitting that it does not have them all. It says a theory should describe "clinical course, outcome, family history, treatment response . . . essential features, associated

features . . . predisposing factors, prevalence, sex ratio, familial pattern . . . etiology, management and treatment" (pp. 2 & 9). Skinner (1981) has an excellent description of the contents of such a theory.

Ideally this would include a precise definition of each type and functional relationships among the various types . . . an explication of the development and etiology of the disorders, a description of prognosis and appropriate treatment interventions and . . . the theory should lead to explicit hypotheses that may be tested. (p. 70)

Others reinforce the special important of etiological elements (Kraepelin, 1899; McDermott, 1981; Wolman, 1978) and prognostic and therapeutic elements. About the latter, McDermott (1981) says, "Diagnoses devoid of prognostic implications are tautologically invalid," and "A diagnosis is valid only when it points to a potentially effective remedy . . . or, should no such remedy exist or be presently known, permits the psychologist to predict the course the . . . problem will take in lieu of treatment" (p. 32). And Kendell (1975) says, "In the last resort all diagnostic concepts stand or fall by the strength of the prognostic and therapeutic implications they embody" (p. 40).

Other elements are also important. The categories should be comprehensive; they should provide adequate

coverage of the population (Andreasen & Spitzer, 1979; Cantwell, 1980; Skinner, 1981; Spitzer, Endicott & Robins, 1978). It is important that the categories or types be discrete, mutually exclusive and internally consistent (Andreasen & Spitzer, 1979; Cantwell, 1980; McDermott, 1981; Skinner, 1981). Specific, concrete, objective operational definitions facilitate this (APA, DSM-III, 1980; Haier, 1980). Spitzer, Endicott and Robins (1978) emphasize the necessity of operational definitions. There should be some way of evaluating the severity of the symptoms (Cantwell, 1980; Skinner, 1981). DSM-III suggests that a good theory should avoid "the introduction of new terminology and concepts that break with tradition" and should be useful in educating professionals (p. 2). Finally, Millon, Green and Meagher (1979) make a practical suggestion, that a good instrument should be "a convenient, easy-to-administer tool, well tolerated by patients, and of appreciable value in providing relevant and useful information to professionals" (p. 536).

A Brief Review of the Literature on Six Personality Types

The system proposed by Kahler (1979, 1982a, 1982b, 1982c, 1982d) comprises six personality types. They

correspond to the following clinical types: obsessive-compulsive, hysteric, passive-aggressive, paranoid, schizoid and sociopathic. Kahler, however, uses different designations for the types--ones that recognize, but do not focus on the pathological qualities involved. These terms will be discussed later. Since one important criterion for a diagnostic system is that it be consistent with the body of knowledge in the profession, "avoiding the introduction of new terminology or concepts that break with tradition" (APA, DSM-III, 1980, p. 2), it is appropriate at this point to provide a brief review of the literature on these six types.

The discussion that follows will draw heavily from a number of personality theorists who seem significantly to have arrived at very similar notions of the major personality types. Brown (1977), the (APA, 1980), DSM-III Eaton, Peterson and Davis (1976), Millon (1973, 1974 & 1981), Pope and Scott (1967), and Shapiro (1965) all show a remarkable degree of consensus not only regarding the types themselves, but also on the specific characteristics of each type. Unfortunately, none of them has much to say about the healthy versions of these types. Nonetheless, their contributions are substantial. Much of the information on the origins of the types and their early conceptualizations comes from the thorough and detailed

survey done by Millon (1981). The reader is referred to this work for a more complete account of the development and history of each personality type.

Obsessive-Compulsives

The first conceptualization of the obsessive-compulsive type came from Germany. Griesinger (1868) used the word "Zwang" and Donath (1897) used "Anankast" to describe this type; others developed the concept further. It is characterized by perfectionism (Rado, 1959) and a meticulous, conscientious and thorough attention to details (Abraham, 1921/1927; Sandler & Hazari, 1960; Walton & Presley, 1973a, 1973b), bordering on the pedantic. These people are hardworking, deliberate and diligent to a fault (Brown, 1977); their work may have a certain "driven" quality (Shapiro, 1965). Because of this perfectionism and a strong fear of making mistakes, they may have trouble being decisive (Kretschmer, 1918) and may be troubled by feelings of ambivalence (Pope & Scott, 1967). This leads either to excessive rumination (Reich, 1949) or, as an avoidance, to a strong preference for situations where the "rules" are clear and objective (APA, DSM-III, 1980; Pope & Scott, 1967; Shapiro, 1965).

Obsessives show a decided fondness for order (Freud, 1908; Fromm, 1947; Lazare, Klerman & Armor, 1966, 1970; Reich, 1949). They enjoy activities involving classifying, structuring and systematizing (Abraham, 1921/1927). They are apt to have trouble with issues related to dirt, time and money (Brown, 1977); that is, they are apt to be excessively neat, punctual and stingy (Abraham, 1921/1927; Eaton, Peterson & Davis, 1976; Freud, 1908/1925; Fromm, 1947; Reich, 1949; Sandler & Hazari, 1960; Verhaest & Peirlout, 1980).

Their emotional and interpersonal styles are characterized by polite formality, reserve, and a lack of expressiveness (Lazare, Klerman & Armor, 1966, 1970; Reich, 1949). They are often stilted, rigid and overcontrolled (APA, DSM-III, 1980; Shapiro, 1965). They are not apt to be enthusiastic, playful, impulsive, spontaneous or relaxed (Brown, 1977). These people may have trouble getting close to others (Eaton, Peterson & Davis, 1976), partly because of the aforementioned lack of emotionality and expressiveness, and partly because they are apt to be demanding and intolerant of irresponsibility (APA, DSM-III, 1980).

Hysterics

The original conceptions of hysteria were traced back to ancient Egyptians and Greeks (Millon, 1981; Chodoff, 1974), but the first clinical descriptions of hysteria were by Griesinger (1845) and Feuchtersleben (1847) and involved qualities such as oversensitivity and capriciousness. Since then others have expanded the concept. Hysteria is usually associated with an intense and insatiable need for affection and approval, and a correspondingly intense fear of loss of love (Freud, 1932/1950; Fromm, 1947; Millon, 1981). This condition usually leads to a heightened suggestibility (Brown, 1977; Klein, 1972; Shapiro, 1965) in the interests of trying to please, and to the related classic hypnotic susceptibility (Spiegel & Fink, 1979). In order to secure this affection, the hysteric may be flirtatious (Reich, 1949), seductive (Fenichel, 1945; Klein, 1972), charming and gregarious (Adler, 1964; APA, DSM-III, 1980; Millon, 1981). The insatiability of this need fosters behavior that is dependent (Chodoff & Lyons, 1958; Freud, 1932), demanding (Janet, 1901), helpless and immature (Millon, 1981). Hysterics are also often described as warm, attention-seeking (Chodoff & Lyons, 1958; Schneider, 1950;

Walton & Presley, 1973a, 1973b), dramatic (Kretschmer, 1926; Pope & Scott, 1967; Shapiro, 1965), and exhibitionistic (Eaton, Peterson & Davis, 1976; Janet, 1901; Turner, 1968).

Excessive and capricious emotionality is one of the hysteric's most salient qualities (Lazare, Klerman & Armor, 1966, 1970). Their emotions are labile and superficial (Chodoff & Lyons, 1958; Klein, 1972; Pope & Scott, 1967; Shapiro, 1965). Concomitantly their thinking processes are apt to be irrational, illogical, impulsive (Klein, 1972; Pope & Scott, 1967) and scattered (Fenichel, 1945; Shapiro, 1965). Hence their behavior is erratic and their judgment is usually poor (Millon, 1981; Shapiro, 1965). Hysterics' social relationships are described as fleeting and shallow (Brown, 1977; Klein, 1972; Millon, 1981; Reich, 1949), although their thinking about these relationships is characterized by naive, romantic sentimentality (Miller & Magaro, 1977; Shapiro, 1965).

A computer search of current research on hysteria turned up surprisingly classical symptoms: fainting and hyperventilation (Mohr, 1980), conversion reactions such as glove anesthesia (Bishop & Torch, 1979; Shogam, 1980), hypochondriasis (Boss, 1979), and, as previously mentioned, seductiveness (Cavenar, Sullivan & Maltbie, 1979), and emotional lability (Slavney & Rich, 1980).

Passive-Aggressives

Just as the Germans seem to have invented the concept of the obsessive-compulsive, the Americans seem to have invented the concept of the passive-aggressive. The term was first used in a War Department technical bulletin (War Dept., 1945) and then later incorporated into the U.S. Joint Armed Services nosology (1949). The original Diagnostic and Statistical Manual of Mental Disorders (APA, 1952) used it also.

The distinguishing characteristic of the passive-aggressive is the attitude that "the world owes me a living" (Menninger, 1940, p. 393). According to Pope and Scott (1967), these people expect "to be loved, taken care of, and satisfied without requirement of effort or reciprocity on their part" (p. 261). When this does not happen, as is usually the case, they typically respond by feeling resentful, disgruntled, frustrated and pessimistic. They often believe they have been cheated and thus feel misunderstood and unappreciated. When they see others who are happy or contented with life, passive-aggressives resent them and feel envious or jealous, not realizing how their own attitude creates their unhappiness (Millon, 1981).

This attitude is clearly reflected in the passive-aggressives' behavior. DSM-III (APA, 1980) states that there is a great "resistance to demands for adequate performance" (p. 328) in work and in personal relationships, but this resistance is expressed indirectly "through such maneuvers as procrastination, dawdling, stubbornness, intentional inefficiency and 'forgetfulness'" (p. 328). Other typical reactions include pouting, sulking, complaining, whining and generally sullen behavior; these people are often moody, petulant, demanding and contrary (Millon, 1981; Shapiro, 1965). They have also been described as egocentric, impatient and impulsive; on the other hand, they can be charming, playful and very entertaining (Brown, 1977; Shapiro, 1965). When these people have problems, they usually find a way to blame others for them (Menninger, 1940; Shapiro, 1965).

Their behavior in relationships should be easy to predict from what has already been said. They are apt to contribute less than their share, and "when others want something . . . [they are] negativistic and frustrating to them" (Eaton, Peterson & Davis, 1976, p. 95). Horney (1939) said, "Because of his excessive expectations of his partner he is bound to become disappointed and resentful;

he is bound to feel unfairly treated . . . regarding himself as victimized and harmed" (pp. 261-263). Problems are caused not only by this chronic disgruntlement, but also, according to Millon (1981), by the fact that passive-aggressives are apt to be "quarrelsome and easily piqued by signs of indifference or minor slights" (p. 254). So their relationships are often unstable, and punctuated by arguments.

Paranoids

Just as the passive-aggressives can be characterized by sullenness, paranoids can be characterized by suspiciousness. Although the word "paranoid" can be traced back to the ancient Greeks, and its general usage through Griesinger (1845), Heinroth (1818), Kahlbaum (1863) and Magnan (1886), its usage as we now know it did not begin until Kraepelin (1921) described a type of patient whose "most conspicuously common feature was the feeling of uncertainty and of distrust toward the surroundings" (p. 268).

This style can best be described by starting with the thinking processes involved. For various reasons, paranoids sincerely believe that others are hostile towards them and seek to control and destroy them (Millon, 1981).

1981). This preconception seriously biases their perceptions (Shapiro, 1965). Add to this belief intensely focused, constantly vigilant, and hypersensitive powers of observation (Brown, 1977; Shapiro, 1965) and one gets the paranoid style. Paranoids are incessantly searching for confirmation of their suspicions (Brown, 1977; Shapiro, 1965)--looking for the slightest sign of the deceit, malice, betrayal, or threat that they are convinced is hiding behind the facade of people's ordinary behavior. There is also a certain amount of self-aggrandizement involved here; one must be very important to arouse such hostility and envy in others (Millon, 1981). Ironically, paranoids' powers of observation are so acute that usually their facts are perfectly correct; it is only the interpretations that are wrong (Shapiro, 1965).

The predominant theme in the emotional life of paranoids is fear. They are terrified of being controlled or dominated by others (Shapiro, 1965). They live in constant (though possibly unconscious) fear of becoming helpless or getting trapped. They are even uncomfortable with the thought of being somehow obligated or vulnerable to anyone. And since, according to Millon (1981), they believe that others want to get them into this position, they must be "constantly on guard, mobilized and ready for

any real or imagined threat" (p. 380). Shapiro (1965) describes their emotional life as an "internal police state" (p. 77).

In this "police state" there is little room for non-emergency related functions. The softer emotions of tenderness, sensuality, and love are often precluded, as are playful qualities: humor and joy (Brown, 1977; Shapiro, 1965). It is more common for paranoids to feel indignant, hostile, jealous or insulted (Eaton, Peterson & Davis, 1976). Millon (1981) states, "They exhibit an edgy tension, an abrasive irritability and an ever-present defensive stance from which they can spring into action at the slightest offense. Their state of rigid control never seems to abate, and they rarely relax, ease up, or let down their guard" (p. 380).

The behaviors that result from this emotional state can easily be inferred. Paranoids are quick to criticize others (Shapiro, 1965) while at the same time reacting very defensively to criticism themselves (Millon, 1981). Their interests are apt to be constricted and pursued in a very purposeful way. There is little room for whim or impulse in their lives. They rarely have a sense of humor and seldom even laugh or feel amused (Shapiro, 1965). Their body posture and facial expressions are apt to be

tense, rigid and overcontrolled (Brown, 1977).

Intimate relationships are difficult for paranoids. Because of their pervasive fear and mistrust, it is hard for them to risk getting close to others. Once in a relationship they are apt to be jealous, hostile, suspicious and critical of their partners. Eaton, Peterson and Davis (1976) state, "They see the worst in everyone . . . they feel slighted and insulted when no offense was intended . . . they feel discriminated and picked on" (p. 114), and they are apt to believe their spouses are unfaithful. Millon (1981) says that they often deny that they need love and nurturing because of their fear of dependency and vulnerability, and that they tend to be unloving, callous and unsympathetic.

Schizoids

The first use of the word "schizophrenia" was attributed to Bleuler (1911/1950), but others (Binet, 1890; Kahlbaum, 1890), using the term "dementia praecox" or their own terms, had described people who were especially quiet-living and preferred to be alone. Hoch (1910) described people "who do not have a natural tendency . . . to get into contact with the environment, who are reticent, seclusive . . . shy, and have a tendency

to live in a world of fancies" (p. 219). Kretschmer (1925) added that this type of person demonstrates "unfeelingness, lack of warm emotional responsiveness. . . to the world around him, which has no interest for his emotional life, and for whose own rightful interests he has no feeling . . . [he is] devoid of humor and often serious without exhibiting either sorrowfulness or cheerfulness" (pp. 172-173). Later Bleuler (1929) himself differentiated the terms "schizoid" and "schizophrenic" to distinguish a personality style from a psychotic state.

One of the most notable characteristics of schizoids is their lack of interpersonal relationships (Chapman, Edell & Chapman, 1980; Eaton, Peterson & Davis, 1976; Guntrip, 1952). They are described as asocial (Klein, 1970; Quitkin, 1981), withdrawn (Chapman, Edell & Chapman, 1980), detached and isolated (Deutsch, 1942; Fairbairn, 1952), and aloof and shy (Eaton, Peterson & Davis, 1976). This is probably due to their lack of warm, tender feelings for others (APA, DSM-III, 1980), their poor social skills, and a notable lack of empathy or interpersonal sensitivity (Millon, 1981; Wolff & Chick, 1980). According to Millon, (1981) they are mostly unresponsive to praise, criticism or any social stimulation, and their social behavior is apt to be formal and impersonal.

Their emotional life seems as impoverished as their social life (Deutsch, 1942). DSM-III (APA, 1980) describes them as bland, colorless, impassive, unenthusiastic and lacking in the ability to experience pleasure. Eaton, Peterson and Davis (1976) and Millon (1981) describe them as cold, apathetic and dull, not experiencing joy, anger, humor or any intense emotion.

The cognitive process of schizoids is also distinctive. In a word, it is confused (Chapman, Edell & Chapman, 1980). It has also been called disorganized (Millon, 1981). Schizoids seem to find it hard to focus or concentrate (Chapman et al., 1980), and are apt to be absentminded and to drift off into daydreams or autistic fantasies (APA, DSM-III, 1980; Eaton, Peterson & Davis, 1976).

The behavioral style of schizoids is characterized by lethargy and lack of energy, vitality or enthusiasm. DSM-III (APA, 1980) and Millon (1981) suggest that since interpersonal relationships are so trying for them, they are apt to prefer solitary activities involving machines, objects or abstractions. With so little outside stimulation to correct or moderate their behavior, it is not surprising that schizoids are often described as eccentric (Eaton, Peterson & Davis, 1976). They truly live in a world of their own (Millon, 1981).

Sociopaths

As schizoids are said to be asocial, sociopaths are called anti-social (Davies & Feldman, 1981). In the last two centuries various terms have been used to designate this personality type. Pinel (1801) used the term "maniacs" to describe people who could think clearly but were impulsive and hot-tempered. Rush (1812) talked about people who felt no shame about lying or hurting others. Prichard (1835) and Kraepelin (1887) called it "moral insanity," Koch (1891) called it "psychopathic inferiority," but the term "sociopath" (Birnbaum, 1914) is the one that seemed to stick. In spite of the variety of terms, the concept was very clearly recognized as far back as 1872 when Lombroso wrote of people who were "emotionally hyperactive, temperamentally irascible, impetuous in action, and deficient in altruistic feelings" (cited in Millon, 1981, p. 188). The concept was further developed as time went on.

As the word "anti-social" implies, the sociopaths' interpersonal relations are characterized by aggressiveness and vengeance (Karpman, 1941; Millon, 1981). Their motto might be, "Do unto others before they do it unto you." They assume that the world is hostile,

cruel and ruthless and that to survive they must be prepared to respond in kind. They have been described as spiteful (Bartemeier, 1930), malevolent and pugnacious (APA, DSM-III; 1980), vindictive and even sadistic (Horney, 1945). They have no trust or respect for authority and thus often get into trouble with the law (Alexander, 1935; Garvey, 1980; Walker, 1981). For these and other reasons it is difficult for them to maintain close, warm, and intimate relationships or even responsible work relationships (Cleckley, 1976; Pope & Scott, 1967). Relationships are also difficult because sociopaths do not seem to need anyone, and tend to be egotistical, callous, insensitive, unaffectionate and totally lacking in empathy for others (Pope & Scott, 1967; Turner, 1968). On the other hand they can be very charming, seductive and socially adept when it suits their purposes (Brown, 1977; Shapiro, 1965).

In the case of sociopaths, the issue of morality (or the lack of it) bears mention. Sociopaths are said to have no conscience (Brown, 1977; Shapiro, 1965) and to feel no guilt (Cleckley, 1976; Karpman, 1941). Thus they feel no compunction about lying, stealing, cheating, etc. (Kraepelin, 1887; Lombroso, 1872-1885; Pope & Scott, 1967). Their only guiding principle is immediate personal

gain (Shapiro, 1965). They are absolutely unrestrained by the values of honesty, loyalty or responsibility. They act as though morality, laws, and social customs do not apply to them (Millon, 1981; Turner, 1968).

Sociopaths' emotional lives are characterized by impulsivity (Bartemeier, 1930; Cleckley, 1976; Pope & Scott, 1967) and actual pleasure derived from dominating, humiliating or hurting others (Millon, 1981). Regarding the former, sociopaths are described as impetuous (Lombroso, 1872-1885), rash (Shapiro, 1965), and unable to tolerate frustration or to delay gratification (Pope & Scott, 1967; Shapiro, 1965; Turner, 1968). Regarding the latter, they are called violent, hot-tempered (Brown, 1977), and vindictive (Horney, 1945). They seem to lack the capacity to feel the gentler emotions: love, tenderness, compassion, kindness. In fact, they are contemptuous of sentimentality in any form (Brown, 1977; APA, DSM-III, 1980). At the same time they are intensely attracted to danger and excitement (DSM-III, APA, 1980; Horney, 1945). They are fearless (Brown, 1977), daring (Turner, 1968), rash, and reckless (Shapiro, 1965), and they constantly seek out adventure, drama, thrills, and new sensations (Alexander, 1923; Miller & Magaro, 1977; Zuckerman, Kolin, Price & Zoob, 1964; Zuckerman & Neeb,

1979). Concomitantly they are easily bored by daily routine (Millon, 1981).

Needless to say, logical, rational thinking is not the sociopaths' forte. Their thinking is quick, ego-centric, and intuitive, so they can be cunning, shrewd and clever when it is necessary to manipulate matters to their advantage (Brown, 1977; Miller & Magaro, 1977), but they do not show insight or foresight (Shapiro, 1965) nor do they learn from their mistakes (Bursten, 1972; Davies & Feldman, 1981). Because they assume that the world is against them (Turner, 1968), and because they never experience planning or intending to do anything, they do not feel guilty, or believe that they are responsible for their behavior, or for the damage they do to others (Shapiro, 1965). Life is a challenge, lived in the present, taking what one can get, and the devil take the hindmost.

Process Theory: A Personality/Diagnostic System

General Comments

It is clear from the previous discussion that there is substantial consensus in the psychological profession on the aforementioned six personality types. Process

Theory (Kahler, 1979, 1982a, 1982b, 1982c, 1982d) is consistent with this tradition but goes beyond it in the development of a new system. Therefore the case for face validity is already strong. With this and the aforementioned criteria in mind (see pp. 33-37), Kahler's theory will now be discussed.

Kahler posits six discrete and mutually exclusive personality types, each encompassing six ranks which cover the range from very healthy or well-functioning down to very poorly functioning. Kahler's names for these types and the corresponding clinical syndromes are as follows:

Workaholics.....	Obsessive-Compulsives
Reactors.....	Hysterics
Rebels.....	Passive-Aggressives
Persisters.....	Paranoids
Dreamers.....	Schizoids
Promoters.....	Sociopaths

Kahler believes that personality types are "assessed" and that the term "diagnosis" is warranted only when there is frequent and/or intense evidence of maladaptive behavior. These six categories theoretically encompass virtually the entire population, so the coverage is comprehensive.

As mentioned previously, there are six ranks within each type. The content of the ranks is different for each type, but the structure is the same. It is as follows:

- Level 3: The highest level of psychological health.
- Level 2: Quite healthy functioning.
- Level 1: The lowest level of healthy functioning.
- 1st degree: The person is in mild distress and resorts to typical ineffective means of getting needs met. Person rescues or invites a rescue.
- 2nd degree: The person engages in particular failure mechanisms and experiences particular bad feelings. The person attacks or invites attack, blames or invites blame.
- 3rd degree: Failure in relationships and/or work; despair.

Each personality type has a particular set of most fundamental needs and a preferred way of being addressed. These are the basic level one needs. If these are met, the person can grow psychologically toward level three. If these are not met, the person will sink down into the "degrees." The theory suggests that people always be approached at their level one, and addressed in their preferred style; then, if they are capable, they will develop and respond to other styles. These styles are called "channels" using the analogy of two-way radio communication, because if two people are on the same channel, they can communicate. The five channels will be described below. Each channel has a corresponding therapeutic style. So this theory also suggests which therapeutic approach to use initially with clients based on their personality type.

If the level one needs are met naturally or in therapy, this theory predicts how people will grow, based upon their personality type. It predicts the order of the phases through which they will progress and the issues with which they will need to deal at each phase. It also predicts the order and content of the dysfunctional phases people will go through if their needs are not met, or if they are under stress. It predicts their failure patterns and mechanisms.

There are concrete, behavioral cues specified for assessing personality type; these involve the person's words, sentence structure, tones of voice, gestures, posture and facial expressions. There is also a diagnostic/assessment instrument (an easy to administer paper-and-pencil test) which can be used instead. It is called the Personality Pattern Inventory (Kahler, 1982a, 1982b).

Because of the clarity and specificity of this system's types and predictions, Kahler believes it could be useful in training therapists and in generating testable hypotheses for research. And since therapists could evaluate themselves according to this system, it could help them choose the clients with whom they will work best, and teach them how they need to progress in order to deal more effectively with a wider range of clients.

A problem remaining with Kahler's theory is that reliability and validity have yet to be assessed thoroughly.

Preliminary Concepts

The concept of the channels must be understood before proceeding. Each of the five channels, or types of communication, has a particular form (requestive, directive, etc.) and content (feelings, thoughts, or behaviors). Each is related to a kind of therapy (Gestalt, Rogerian, etc.) and each is particularly useful in inviting people out of a certain "driver." Drivers are stereotypical ineffective ways of meeting one's needs. They are learned in childhood and are "early attempts at receiving conditional attention from parent figures, that compromised our feelings about our own self-worth" (Kahler, 1982c, p. H). They will be described with their respective channels.

Channel one is an interruptive style of communication, for use during crises or emergencies. It is characterized by:

directives, imperatives, or commands
aimed at the senses (touch, smell, taste,
hearing or sight) of another or of self.
. . . The interventive channel is very
useful when people are getting "out of

control" . . . [and it] proves useful in negotiations. . . . In a hospital setting, this channel helps deal with patients in physical pain and emotional distress as well. (Kahler, 1982c, p. C-3)

This channel is especially useful in inviting people out of a "hurry up" driver: a state where people are rushing, interrupting, speaking too rapidly, or agitating. The associated therapy is crisis intervention.

Channel two is a directive style used in giving commands aimed at another person's thinking or behavior. "In channel two communication, one person offers a command, imperative or directive, and another person accepts this offer from a clear thinking part, responding crisply as a computer would in taking the command" (Kahler, 1982c, p. C-5). This is useful in inviting people out of a "be strong" driver: a state where people speak in a monotone, will not show their feelings, and act in a cold, hard, dispassionate way. The related therapies are behavior modification and Aesculapian type confrontive therapy.

Channel three is a requestive style of communicating, aimed at one's thinking, involving the exchange of information. "Feelings are not involved, questions are answered directly . . . [and it is] a most important channel in business, allows for efficient exchange of

ideas and data" (Kahler, 1982c, p. C-6). It is useful for inviting people out of a "be perfect" driver: a state where they overqualify, use big words when little ones would suffice, over-question, and act accusatory, righteous, stern and precise. The therapy associated with this channel is Rational-Emotive Therapy.

Channel four is a nurturing style aimed at people's feelings. It is warm, caring and affective. It does not seek information but instead invites people to feel good and appreciated. It invites people out of a "please you" driver: a state where they may whine, raise their voice at the end of each sentence (inviting approval), and stand with shoulders in and head forward, nodding and looking up with raised eyebrows. The associated therapy is Rogerian, or client-centered.

Channel five is a playful style of communication, aimed at one's feelings. As with channel four, this does not seek information and does not ask the person to think. It is a fun-loving childlike style, where both people share their feelings. It is useful for inviting people out of a "try hard" driver: a state where they will not ask or answer questions directly and may look pained, as if struggling to understand. Gestalt Therapy is related to this channel.

The Six Personality Types

Workaholics/Obsessive-Compulsives. The personality type that corresponds to the obsessive-compulsive clinical syndrome is called Workaholic in Kahler's system. According to Kahler (personal communication, August 29, 1983), Workaholics comprise 30% of the population and 75% of them are men. "Workaholics show thinking first . . . In casual conversations, they prefer intellectual matters rather than emotive kinds of interactions" (Kahler, 1982c, p. K-6). They are usually clear-thinking, logical, organized and responsible. Their most fundamental needs are for time structure and for recognition for their work. "Time structure refers to the need for knowing what is to be done and when" (Kahler, 1982c, p. D-4). Recognition for work involves a desire for "confirmation that what he has done is noticed. The person is motivated by awards, bonuses . . . ways of recognizing that he has done a good job" (Kahler, 1982c, p. D-1). "The Workaholic needs to be recognized for his thinking abilities and accomplishments. He wants to know that you are aware of how hard he works, how responsible he is, and what a good detail man he is. He needs to satisfy his achievement desires by reaching goals that he is proud of" (Kahler, 1982c, p. K-7). The

Workaholic's preferred communication style is channel three.

If these first level needs are not met, Workaholics sink to first degree and get perfectionistic (the "I must be perfect" driver). Drivers correspond to psychosexual stages. In this case it is early anal. Their sentence patterns will have parenthetical clauses. They will use unnecessary qualifications, measured tones of voice punctuated by finger or hand gestures. Their facial expressions will look pressured and their postures will be stiff and robot-like. They will try to think through their feelings and may get obsessive, or they may get compulsive, work too hard, not delegate enough, and have trouble with stress or "burn-out." Their lives will have an "until" quality to them. They will not allow themselves to relax or have fun until . . . (all their work is finished perfectly, they graduate, etc). They may cause problems for themselves at work with this pattern if they do not do necessary jobs until the previous one is done perfectly. They will use rationalization and intellectualization as defense mechanisms. Mackinnon and Michels (1971) add that they also may use emotional isolation.

If their needs are still unmet, they may sink to second degree. At this point they will over-control either themselves, by organizing obsessively, or others, by blaming or attacking people for not being responsible or thinking clearly enough. The issues are apt to involve money, order or cleanliness. They will feel angry, frustrated or triumphant. At their worst (third degree) they will reject others (i.e. firing or divorce) and feel depressed, worthless, lonely or unwanted. They may overwork themselves into a heart attack.

On the other hand, if their basic needs are met, they will grow psychologically in a particular way. At level two they will first become playful and fun-loving and respond well to channel five, then they will become more nurturing and affectionate and be open to channel four. At level three they will be comfortable with commands (channel two) and criticism of their behavior. These upper levels are incorporative; that is, level three includes levels one and two, and so forth. As growth occurs, Workaholics can be said to go through a Rebel phase, a Reactor phase and a Dreamer phase, respectively. In each phase they will take on the appearance, behavioral characteristics, traits, psychological needs, and even defense mechanisms and therapeutic issues of the

respective personality types. Both positive and negative qualities will be evident at first; later just the positive qualities will remain. But they will still be Workaholics and thus their growth will follow this pattern, and their deterioration under stress or unmet needs will follow the pattern described.

In appearance Workaholics will be very neat and tidy. Their clothes will be pressed and probably of high quality. Their hair will be in place and they may appear "business-like." They will be especially well suited to jobs that require hard work, good organization and perfectionistic attention to details. Their offices and homes will be functional, organized and neat.

As children Workaholics were expected to be overly responsible, and they may have felt appreciated or loved only when they were well behaved. Usually they are first born, or only, children. They may have decided not to express their feelings (except, perhaps, anger) but to put all their energy into being "good." This probably was the best adaptation they could make to their family system.

In therapy with Workaholics it is best to begin with Rational-Emotive therapy or a similar kind of approach that uses channel three, gives them information and thinks with them. Later they will be willing to start dealing

with their emotions, and, after expressing their anger, usually they will need to face their sadness or grief. They may have come to therapy for stress or depression, but the real issues will involve accepting themselves as imperfect beings, and becoming more open to their emotions.

If the wrong kind of therapy or the wrong channel is offered to them consistently, they will sink to first degree as described above. If the right kind of therapy and channel three is offered to them (and they learn to meet their needs) they will improve, and as they do they will prefer the therapies and channels that correspond to the phases they are passing through. (They will also use the relevant channels themselves.) A "map" of the Workaholic's process looks like this:

	(what they will show and want addressed)	(channels they are open to)	(Phase)
Level 3:	Actions	2	Dreamer
Level 2:	Emotions	4 5	Reactor Rebel (Promoter)
Level 1:	Thoughts needs: time structure, recognition for work	3	Persister
1st degree:	"Be Perfect" driver	Failure Pattern:	"I can't, until ..."

2nd degree: Feels: angry,
triumphant

Failure Mechanism:
over controls

Warning signals:

1. Frustrated with others who don't think the same
2. Attacking
3. Issues of money, orderliness or cleanliness

3rd degree: Feels: depressed
worthless, lonely,
unwanted

Behavior: fires or
rejects others and
is alone

Reactors/Hysterics. Reactor is Kahler's term for the personality type that corresponds to the hysteric clinical type. According to Kahler (personal communication, August 29, 1983), Reactors comprise 30% of the population and 75% of them are women. They show their feelings first and are warm, nurturing, and concerned about others. They enjoy taking care of others and are good at sensing and responding to others' feelings. "The level one Reactor wants to be appreciated for herself as a person. She desires to be nurtured by a warm, compassionate person who will give unconditional attention, let her know that she is important and will listen to her feelings" (Kahler, 1982c, p. K-5). They also need to nurture themselves with sensory pleasures. They appreciate "sights, smells, touches, tastes and sounds." They want the environment

"pleasant smelling, pretty to look at . . . with soft comfortable furniture and pleasant meals" (Kahler, 1982c, p. D-4). So Reactors' two most basic needs are for recognition of themselves as people, and for sensory stimulation. Their favorite communication style is channel four, a nurturing, unconditional style aimed at the emotions. They are well suited to jobs that involve adapting to or taking care of others.

If their basic needs are not met, they will sink to first degree where they will try very hard to please others. (This corresponds to the Oedipal stage.) "They ingratiate with over-adapting 'gee, you're wonderful' behavior. They frequently tuck in their chins to force a looking up to please, causing a raising of the eyebrows, often accompanied by fluttering eyes. They may talk in a higher than normal pitch" (Kahler, 1982c, p. K-4). Their typical sentence will start positively, then have a "but" and end unhappily. They may believe that "if things are going too well, something bad will happen" and they may unconsciously create these situations. They will have trouble being assertive, saying "No" appropriately, or asking for what they want. They will use denial and internalization as defense mechanisms. Mackinnon and

Michaels (1971) add that they may also use repression and conversion reaction.

If their needs are still unmet, they may sink to second degree where they will make mistakes and invite others to blame or attack them. They will feel sad, anxious, confused, worried, inadequate or depressed. They will lack assertiveness and may laugh at themselves inappropriately or act "stupid." At their worst (third degree), they will invite others to fire or reject them, and they will feel lonely, depressed, unloved, unwanted or desperate.

If their basic needs are met consistently, they will first become playful and go through a Rebel phase (and be open to channel five). Then at level two, their Work-aholic phase, they will become more responsible and organized, will want recognition for their work and will be open to channel three. At level three, their Dreamer phase, they will enjoy being alone and independent, and will be open to channel two.

Reactors tend to dress in soft colors and wear jewelry and perfume or cologne. They will want attractive hairstyles and will enjoy getting attention for their appearances. Their offices and homes will be warm, cozy and comfortable.

As children they probably received a good deal of unconditional attention and may have gotten the impression that their parents did not want them to grow up. They also were given the impression that they could "make" others happy, and they put most of their energy into doing so even at the expense of pleasing themselves. In the interests of this effort, they may have suppressed feelings of anger and acted sad or hurt instead. This probably was the best adaptation they could make to their family system.

In therapy with Reactors Kahler believes that it is best to start with a Rogerian or client-centered approach. This style is warm, nurturing and affective (channel four). Later they may appreciate more playful and informational styles. Even if their presenting problems have to do with feeling unappreciated or lonely, they will still need to learn how to be assertive and express anger appropriately. They need to decide that it is all right for them to please themselves and to ask for what they want.

The Reactor's process looks like this:

	(channel)	(phase)
Level 3: Actions	2	Dreamer
Level 2: Thoughts	3	Workaholic

Level 1: Emotions	5 4	Rebel (Promoter)
needs:	recognition for self as a person, sensory stimulation	
1st degree:	"Please you" driver	Failure Pattern: Things go well, then something bad happens
2nd degree:	Feels: sad, worried, anxious, confused, inadequate, depressed	Failure Mechanism: makes mistakes Warning Signals: 1. Lacks assertiveness 2. Laughs at self inappropriately 3. Acts "stupid"
3rd degree:	Feels: lonely, depressed, unloved, unwanted, desperate	Behavior: gets fired or rejected

Rebels/Passive-Aggressives. Passive-aggressives are called Rebels. According to Kahler (personal communication, August 29, 1983), Rebels comprise 20% of the population, and 60% of them are female. "Rebels react with behaviors and emotions first, not thoughts. Rebels want attention and need to be active" (Kahler, 1982c, pp. K-12 & K-13). They are often fun, playful, energetic, and creative and they have a great joy for life. They want to be treated playfully and enjoy frequent interactions with others. They "want their creativity to be appreciated. They need to make contact with people who are fun and spontaneous" (Kahler, 1982c, p. K-13). They may enjoy loud music, games, bright lights, mechanical devices,

posters or pets. They will seek out exciting activities, possibly including drugs and sex. Since they are creative they can make good interior designers, advertisers and rock musicians. Their favorite communication style is channel five: a playful, fun-loving style.

If these needs are unmet, Rebels sink to first degree where they will "try hard" instead of succeeding. This is the late anal psychosexual stage. They will not ask or answer questions directly; "They will say things like 'I can't' when they really can, 'I don't know,' when they could know, 'That's hard,' 'I'll try' or 'Huh?'" (Kahler, 1982c, p. K-12). They will show pained or wrinkled expressions, clenched fists and strained or pressured voice tones. They will lean forward with their heads up and may mumble. Their failure pattern will be to get themselves trapped (or to believe that they are) and to wait for someone or something to change. Their motto might be, "Damned if I do and damned if I don't." Reaction formation will be their defense mechanism.

At second degree Rebels will set themselves up to be rejected or fired, and not understand why people are angry at them. They expect others or "life" to do things for them and get angry or blame them when they do not. They will have gotten themselves stuck and will be blaming

things, situations or others, and waiting for a rescuer. They will feel angry, bored, vengeful, jealous or hurt and will act negativistic and complaining. At their worst (third degree) they will feel depressed, cornered, lonely, unloved or hopeless. They will have arranged to get fired or rejected and probably will have engaged in sabotage at work or in their private lives.

If their needs are met they will first become more nurturing toward others, then more organized and clear thinking, and finally more able to enjoy quiet, reflective time alone.

Rebels will dress casually, or the way their friends do. Their homes or workplaces may have posters, art works, games, toys or pets in them.

When they were growing up, Rebels usually had one parent who was critical and controlling and another who was a rescuer, so they learned to equate love with rescuing. They were not encouraged to grow up and become responsible, successful human beings. Given these circumstances, they probably came to believe, "I am special and people should do things for me," and "If people don't make me feel better, it's their fault."

Gestalt therapy, preferably in groups, is the treatment of choice at first, because it is playful and

stimulating (channel five). The therapist should confront their behavior playfully, using exaggeration and kidding. Then the therapist can invite them to accept nurturing and teach them to nurture themselves. Rebels may also need to re-examine unconscious decisions not to grow up or succeed.

A chart of the Rebel's process looks like this:

Level 3: Thoughts	2	Dreamer
	3	Workaholic (Persister)
Level 2: Emotions	4	Reactor
Level 1: Reactions	5	
needs: contact, excitement		
1st degree: "Try Hard" driver		Failure Pattern: "Damned if I do, damned if I don't"
2nd degree: Feels: angry, blameful, bored, vengeful, hurt, jealous		Failure Mechanism: blaming Warning Signals: 1. Negative and complaining 2. Says "yes, but..." 3. Blames things, situations and other people
3rd degree: Feels: depressed, cornered, lonely, unloved, hopeless		Behavior: gets fired or rejected (sabotages before or after they leave)

Persisters/Paranoids. The term that corresponds to paranoid is Persister. According to Kahler (personal communication, August 29, 1983), Persisters comprise 5% of the population and 75% are male.

Persisters show thoughts first. Once someone has initiated conversation, [they] respond with thinking and engage in conversation. . . . Persisters want other people to admire and respect their belief systems. Listening to their opinions and recognizing their accomplishments are important. They need to act on their beliefs to make an impact on the growth of others. (Kahler, 1982c, pp. K-8, & K-9)

They are very observant, hard-working, and goal-oriented. They have high ideals and expectations and a concern for the quality of their work. Their two basic needs are for recognition for their work (as with the workaholics) and for conviction. The latter "refers to having a commitment to a belief, an opinion, or a judgment. It is important [to them] that other people believe as they believe" and share their values (Kahler, 1982c, p. D-2).

If these needs are not met, Persisters sink to first degree where they insist that others measure up to their expectations. This corresponds to the early anal psychosexual stage. They will overqualify, overquestion, and use big words when little ones would suffice. Their tones of voice will be strident, accusatory and righteous, their gestures calculated and precise. Their postures

will be rigid, stiff and aloof, probably with their heads tipped up, and their facial expressions will be stern and severe. Like the Workaholics, their sentence structure will contain parenthetical statements and qualifying phrases, and their private and work lives will have an "until" quality to them, deferring pleasure and relaxation, or even necessary work, until everything is done perfectly. They will also manifest a secondary driver: "Be strong." This corresponds to the oral psychosexual stage. "At such . . . times, he denies that he is in charge of his own thoughts or emotions with such reflections as 'It occurred to me; or 'I feel that . . .'" (Kahler, 1982c, p. H-13). The tone of voice will be monotonous, the posture rigid and frozen, and the facial expressions cold and expressionless. Projection and reaction formation will be their defense mechanisms.

At second degree Persisters may cause problems for themselves by pushing their beliefs or crusading, in a way that unconsciously invites others not to listen to them. At this stage they are apt to feel indignant, righteous or triumphant. They will be suspicious and very sensitive to criticism. They will believe that their opinions are the only right ones and may behave in an arrogant, persecutory, critical or fault-finding way toward others.

At third degree they will reject others or be rejected and end up alone. They will feel depressed, cornered, worthless, unloved, unwanted or lonely.

On the other hand, if their needs are met, they will first become very loving and nurturing to others (Reactor phase), then playful (Rebel phase) and finally at level three they will even be comfortable with commands and criticism of their behavior.

Persisters will dress "in a basically conservative fashion that generally fits with what a person should wear in his or her organization" (Kahler, 1982a, p. 4). They will not want to draw people's attention by the way they dress. Their homes or offices will be "organized and functional. The furniture should be organized and kept in proper perspective. They appreciate pieces that reflect a certain cultured, cosmopolitan or sophisticated atmosphere" (Kahler, 1982a, p.6).

Persisters grew up in houses where facts and beliefs may have been confused. They were given conditional approval when they were responsible and "behaved as they were supposed to," but probably not much unconditional love just for being themselves. They may have been overly criticized, manipulated, or even abused as children and may have decided that it was safest to think clearly, act

grown up, hide their feelings and not trust or get close to anyone. And perhaps this was a good adaptation to their family system.

Therapy with Persisters needs to proceed slowly and carefully. Communication should be requestive and respectful, and should address their beliefs and opinions (channel three). The therapist should also be respectful of their psychological and physical space. The therapist should invite them to think through their beliefs and discover the contaminations for themselves. They may well bring up issues related to staring or being stared at, or trusting or getting close to others. They will need to learn to nurture themselves and to become more open to their feelings. Once they have done this, they will be able to work through their underlying fear of being alone. They will also need to learn to accept themselves and others as imperfect and sometimes weak beings.

The Persister's process looks like this:

Level 3: Actions	2	Dreamer
Level 2: Emotions	5	Rebel (Promoter)
	4	Reactor
Level 1: Thoughts	3	Workaholic
needs: recognition for work,		conviction
1st degree: "You be Perfect" driver		Failure Pattern: "I can't, until..."

2nd degree:	Feels: triumphant, jealous, righteous	Failure Mechanism: pushes beliefs, and crusades Warning Signals: 1. Overly sensitive to criticism 2. "My opinion is the only right one" 3. Overly suspicious 4. Righteous
3rd degree:	Feels: depressed, worthless, cornered, unloved, unwanted alone	Behavior: fires or rejects others, gets fired or rejected

Dreamers/Schizoids. The corresponding term for schizoids is Dreamers. According to Kahler (personal communication, August 29, 1983), Dreamers make up 10% of the population, and 50% of them are female.

The Dreamer shows inactions initially, not emotions or thoughts. He sits passively and patiently, not intending to invite any frustration, but rather absorbed with his own internal processes. A Dreamer is likely to be seen alone or with one other person talking to him. If a Dreamer came into your office, he would wait for you to initiate conversation. You would have to continue to supply the initiations, as the Dreamer is primarily a responder. Brief responses are quite common. (Kahler, 1982c, p. K-10)

They are not competitive or aggressive, but can be very imaginative and are especially well suited to jobs that would seem lonely or boring to others, such as

working with computers, machines or tools. As to basic needs, "Dreamers require direction and time structure. Allow them to have their own 'cubby hole' where they are not expected to interact with people. They need to arrange alone time for self-reflection" (Kahler, 1982c, p. K-11). They prefer a directive style of communication (channel two).

If their basic needs are not met, Dreamers will sink to first degree and show a "be strong" driver. This is the oral psychosexual stage. They will say things like "It occurred to me" or "That makes me feel . . ." as though some outside force causes them to think or feel as they do. And, like the Persisters, they will speak monotonously with expressionless faces and rigid postures. Their sentence structure is apt to be tangential; they often will not finish what they start. And they may believe (and unconsciously create situations so that) they will never get what they most want. They will use depersonalization as their defense mechanism.

At second degree they may cause problems for themselves by their inaction. They may wait passively for someone to tell them what to do. They will feel hurt, embarrassed, inadequate, shy, fearful or confused. They will rarely finish anything, may have recurring illnesses,

and may go into sustained withdrawal with a quality of hiding. At third degree they will feel hopeless, lonely, unwanted, unloved, worthless, desperate or depressed. They may get fired or left alone and may become psychotic.

But if their needs are met, they will first become more hardworking, organized and clear-thinking (Workaholic phase) and at level three they will become playful and loving (Rebel and Reactor phases, respectively).

Dreamers are apt to dress absent-mindedly. They may put on what they have left in the closet or what the weather "dictates." They may not notice if their socks or clothes do not match. Their homes or offices will be just places to live or work. They will prefer places to themselves, out of the flow of traffic. Because they are not apt to be emotionally expressive, their faces will look young and unwrinkled.

When they were growing up, Dreamers may often have been left alone or ignored. They are usually only children or last born children. They may have believed that the best way to cope was to close down their emotions, suppress their desires, and not expect much from life. Their parents probably did not encourage them to express their feelings or voice their thoughts, and may only have attended to them when they were sick, thus

possibly reinforcing illness as a life style. These adaptations may actually have helped them as children, but would cause trouble as they became adults.

Behavior therapy is the treatment of choice at first with Dreamers. Channel two is the best communication style, addressing actions. It is best to tell them to do a short list of behaviors within a certain time. They may need help improving their social skills; role plays and rehearsals will be useful. It will be important to go slowly with them, to do one thing at a time, and to get closure before proceeding. They may well have an underlying fear of being alone and a suppressed desire to be loved and to belong, but they will need time, therapeutic support and nurturing before they will be ready to face these. If the therapist moves too quickly (or even if he or she does not), Dreamers may just stop coming to sessions, another example of not finishing what they start. For therapeutic success, they will also need to give themselves permission to think and feel and be healthy.

A chart of the Dreamer's process looks like this:

Level 3: Emotions	4	Reactor
	5	Rebel (Promoter)
Level 2: Thoughts	3	Persister (Workaholic)

Level 1: Inactions 2
needs: solitude, time structure, direction

1st degree: "Be strong" driver Failure Pattern:
"I'll never get
what I want most"

2nd degree: Feels: hurt,
embarrassed,
inadequate, shy,
fearful, confused Failure Mechanism:
passively waits
Warning Signals:
1. Sustained
withdrawal
2. Recurring
illnesses
3. Projects
started
and not
finished

3rd degree: Feels: hopeless,
lonely, unwanted Behavior: gets
unloved, worthless fired or rejected
desperate, depressed and is alone; may
be psychotic

Promoters/Sociopaths. The term corresponding to the sociopathic clinical syndrome is Promoter. According to Kahler (personal communication, August 29, 1983), Promoters are 5% of the population and 60% of them are male. They are clever, tough, street-wise, adaptable "survivors." They can also be very charming and socially adept. Because of their charm and adaptability, they can be very persuasive and thus make excellent salespeople or entrepreneurs. "They need to find exciting things to do and energetic people to be around. Consistent expectations with explicit instructions are very important"

for them, especially at work (Kahler, 1982c, p. K-15). So channel two is their favorite communication style. With the right incentives, like commissions based on sales, they can be very successful and will enjoy making money and buying expensive things. They are not as well suited to routine jobs.

If their needs for excitement and stimulation are not met, Promoters will get themselves into trouble in predictable ways. They will create their own excitement, possibly in irresponsible ways such as promiscuity, drug abuse, gambling, or reckless driving. They will probably have trouble with long-term commitments to jobs or relationships or future plans. They will tend toward hedonism. Their driver will involve expecting others to be strong for them (oral psychosexual stage). They will say things like "How does that make you feel?", will speak monotonously and dispassionately using robot-like gestures and a rigid posture, and their facial expressions will be cold, hard, and stony. Like the Rebels, they may corner themselves into situations where they are "damned if they do and damned if they don't." They will use the defense mechanisms of reaction-formation, projection and denial.

At second degree they will manipulate or "con" others by lying, stealing or cheating. They will break rules or

just simply ignore them. They will enjoy setting up arguments among people or making fools of others. They might be vindictive and might even abuse or assault people to get their own way. They will feel vengeful, frustrated, blameful, blameless or triumphant. They will not feel fear, guilt or remorse. At third degree they will get fired or rejected by others and might even go to jail. They will feel trapped, unwanted, unloved, worthless, depressed or despairing.

On the other hand, if their needs are met, they will grow to be playful, loving and clear-thinking (in that order).

Promoters tend to dress "in bright colors. They like expensive looking clothes and jewelry" and are apt to wear their shirts or blouses open (Kahler, 1982a, p.4). They prefer their homes or offices to be "expensive looking with thick carpets and fancy furniture" (Kahler, 1982a, p.6). They may decorate them in bright colors and want people to be impressed by them.

Promoters often had difficult childhoods. They usually come from broken homes and may have been abandoned during the first six months of life. They may have decided never to get close to anyone again. They learned to cope by denying fear, suppressing guilt or remorse and

learning to be street-wise. They may have joined a gang, or enjoyed war games or tattoos. Often they began engaging in some delinquent behaviors (lying, stealing, cheating or fighting) at a young age.

The therapist should begin by confronting behaviors and being consistent and directive. The treatment of choice is an Aesculapian-type group where there is much stimulating confrontation and strong incentives to think. The first goal is to encourage the spontaneous release of the fear they have been suppressing. Then Promoters need to learn to nurture themselves and others. After this they can learn to think clearly, to behave ethically and to plan for the future. Along the way they will need to begin trusting and getting close to others.

A chart of the Promoter's process looks like this:

Level 3:	Thoughts	3	Persister (Workaholic)
Level 2:	Emotions	4	Reactor
		5	Rebel
Level 1:	Actions	2	
	needs:	excitement, stimulation, consistent expectations and explicit directions	
1st degree:	"You be strong" driver		Failure Pattern: "Damned if I do, damned if I don't"

2nd degree:	Feels: vengeful vindictive frustrated, blameful, blameless, triumphant	Failure Mechanism: manipulates Warning Signals: 1. Sets up argu- ments among others. 2. Cons 3. "Makes fools" of others 4. Ignores or breaks rules
3rd degree:	Feels: depressed, unwanted, unloved, despairing, worth- less, trapped	Behavior: gets fired or rejected, or possibly put in jail

Concluding Comments

Although a particular style of therapy is suggested for each personality type, clients will respond to, and may well prefer, the kind of therapy that matches the phase they are in. Phase-relevant therapy is also appropriate because it suits the currently salient defense-mechanisms and therapeutic issues.

Therapists could use this theory to place themselves and assess their level. This evaluation would suggest which channels and therapy styles they could use well and, correspondingly, with which clients they would be able to work best. It would also suggest how a therapist might grow and the issues that he or she would need to face in

order to be able to work successfully with a wider range of clients.

When therapy is not succeeding, this theory suggests what the problems might be. For example, if a therapist is consistently using the wrong channel, the client will usually stay at first degree and not make progress.

One important criterion for a personality/diagnostic system is that it generate testable hypotheses. This system does so. Many of the criteria described earlier are satisfied by this new system. It remains to be seen whether questions of reliability and validity can be satisfactorily answered.

Summary

It is apparent from this discussion that an adequate personality/diagnostic system is necessary. The systems currently in use all have debilitating flaws. It remains to be seen whether Process Theory might improve upon and replace such systems.

CHAPTER III

DESIGN AND METHODS

Population and Sample

The population for this study was defined as adults and children in Boston, Massachusetts and the surrounding area. Since it was not feasible to use an unrestricted random sampling method to obtain the needed cases, a stratified sampling plan was adopted (Wechsler, 1955). The variables which were stratified included age, sex and race. The 1980 U.S. Census (United States Bureau of the Census, 1980) was used to determine the percentages of each variable in the sample. The stratifications were as follows:

Age:	0-19	32%
	20-44	37%
	45-85	31%
Sex:	Male	48.5%
	Female	51.4%
Race:	White	83%
	Black	12%
	Native American & Other	3.5%
	Asian	1.5%

Practical considerations ruled out stratification along such variables as occupation and socio-economic status. The factors of urban-rural residence and education level were accommodated as much as possible.

The sample consisted of 20 "clinical" and 20 "normal" subjects. Clinical subjects were operationally defined as people seeking professional help for emotional problems, and normal subjects as people who were not seeking such help. This was a stratification of sorts across the range of well-functioning to poorly-functioning. The clinical subjects were referred by the South Boston High School Counseling Service and by the South Shore Mental Health Center in Quincy, Massachusetts. These agencies were asked to supply their most severely disturbed patients to present as wide a range as possible in the level of functioning. The normal subjects came from high schools, colleges, businesses and nursing homes.

Applying the stratification criteria to this sample size meant that in each of the two groups, there were 10 males and 10 females. Also in each group were seven people under the age of 19, seven between the ages of 20 and 44, and six people over the age of 45. The average age was 35.5 years. Also, each group had 17 white people, two black people and one Asian. It proved unfeasible to find Native Americans, Pacific Islanders or Aleuts that fitted the other criteria. Hispanics were not included as a category since they can be of any race. Among the 40 subjects, 16 had some high school education, 16 had some

college education and eight had some graduate education. Finally, there was a balance of rural to urban residents: there were 17 rural residents and 23 urban residents.

Experimental Design and Data Collection

After signing an informed consent form (see Appendix A) all subjects were given a brief structured interview (see Appendix B). In the course of the interview, the experimenter offered Process Theory's four normal channels of communication (excluding channel one, the emergency channel). The rationale behind the interview is that personality types will respond best to their favorite channels and next best to the channel corresponding to the phase they are in. The interview questions were also formulated to avoid differentiating between clinical and normal subjects. The interviews were tape recorded and the subjects' behavior and appearances were recorded on the Subject Form (see Appendix C). The taped interviews and subject descriptions, with only age, sex and number codes as identifying information, were sent to three diagnosticians who were considered experts in Process Theory. These three "judges" were Dr. Taibi Kahler; Dr. Michael Brown, a licensed psychologist in Michigan; and Dr. Terence McGuire, the consulting psychiatrist for the National Aeronautics and Space Administration.

Using the subject's responses to the various channels, as well as the words, sentence structures, and tones of voice on the tapes, and the written descriptions of the subjects' gestures, postures, facial expressions and appearances, these judges assessed the subjects' personality types and phases. They recorded their assessments of the 40 subjects on the Assessment Form (see Appendix G). The assessments were used for two purposes. The first was to evaluate the interdiagnostician reliability. The second was to provide an assessment of external validity, as the normal subjects should be assessed at higher levels of functioning than the clinical subjects.

These experimental methods are supported in the professional literature. Assessing the subjects in blind fashion is a technique strongly recommended to prevent experimental contamination (Mazure & Gershon, 1979). Tape-recording client interviews in diagnostic studies is recommended by Grove, Andreasen, McDonald-Scott, Keller and Shapiro (1981) as especially useful in the study of "observer bias."

In order to assess accurately interdiagnostician agreement, other confounding sources of variance must be eliminated. In describing the method of diagnosing a subject on the basis of tapes (the "passive observer"

method), Cloninger, Miller, Wette, Martin and Guze (1979) say, "Neither temporal changes nor inconsistent history contribute to discordance" (p. 93). Also eliminated are subject variance, occasion variance and information variance (Andreasen & Spitzer, 1979). What remains are the exact variables to be measured: "Observation variance . . . when two clinicians look at the same information or data, but observe it differently"; and "Criterion variance . . . when two clinicians observing the same patient data make different diagnoses because they are using different criteria" (Andreasen & Spitzer, 1979, p. 380).

Personality/diagnostic tests were also given to the subjects. The clinical subjects took the Millon Clinical Multiaxial Inventory (MCMI) (Millon, 1983; reprinted with permission) (see Appendix D) in the interest of assessing convergent validity.³ Skinner (1981) says:

In the development of the MCMI Millon (1977) followed the construct validation paradigm described by Loevinger (1957) and Jackson (1971). The MCMI manual provides a detailed account of the theory specification, internal validity analyses, and external validation. Thus, the careful work by Millon provides a good illustration of a classification that has been developed according to a construct validation framework. (p. 80)

³ For reliability and validity data on the MCMI, see Millon, 1983, pp. 47-62.

Since the MCMI arrived at the six categories comprising the Process Theory model, this was prima facie evidence of the theory's construct validity. And since the MCMI corresponds to axis II of the DSM-III, convergent validity with it was evaluated vicariously.

Unfortunately, the MCMI is only valid for clinical populations, so the normal subjects were given the Personality Pattern Inventory (PPI), Process Communication Model form (Kahler, 1982b; reprinted with permission) (see Appendix E). Since only preliminary research has been done on this instrument (see Appendix F) it did not provide evidence for validity, but was instead an additional measure of reliability, in this case across diagnostic measures.

The MCMI and PPI tests were sent for scoring. When the test results returned, they were coded onto the Assessment Form (see Appendix G). In the case of the PPI, this coding was relatively straightforward; the personality type is clearly printed on the results printout, and the phase is deduced from the personality type that corresponds to the first psychological need with a score less than 100 (see Figure 1). There were a few tests that had a notation saying "questionable validity." In all these cases, the scores were unusually high, probably due to subjects' erroneously failing to rank the

PERSONALITY PATTERN INVENTORY

Name: JCI
 Comment: BPA 6/14/84

PERSONALITY TYPE: Workaholic

RELATIVE INTERACTION SCORE: 61.52

CHARACTER STRENGTHS: responsible, logical, organized:

COMPONENTS	SCORE	COMPONENTS	SCORE
1 INTERACTION STYLES	59.90	6 CONTACT PERCEPTIONS	72.73
Democratic	100	Thoughts	100
Benevolent	73	Opinions	84
Autocratic	39	Emotions	71
Laissez Faire	28	Actions	37
		Reactions	26
		Inactions	4
2 PERSONALITY PARTS	59.15	7 INTERACTION SPAN	47.50
Computer	100	Workaholics	83
Comforter	72	Persisters	80
Director	38	Reactors	50
Emoter	27	Promoters	32
		Rebels	24
		Dreamers	6
3 CHANNELS OF COMMUNICATION	52.85	8 DRIVER BEHAVIORS	73.11
Requestive	100	Be perfect	100
Nurturative	67	Be perfect I	84
Emotive	24	Please	71
Directive	19	Be strong-f	37
		Try hard	27
		Be strong	5
4 PSYCHOLOGICAL NEEDS	70.40	9 FAILURE PATTERNS	58.02
Rec-work/time-struct	100	Until	100
Conviction	81	Almost II	70
Rec-person/Sensory	68	Always	36
Incident	34	Almost I	26
Contact	23	Never	4
Solitude	1		
5 ENVIRONMENTAL PREFERENCES	52.14	10 FAILURE MECHANISMS	69.36
active-withdrawing	100	Over-controls	100
active-involving	70	Pushes beliefs	79
Passive-involving	36	Makes mistakes	66
Passive-withdrawing	7	Manipulates	52
		Blames	32
		Passively waits	0

Figure 1. Printout of Results from the PPI (Kahler 1982b)
 Reprinted by permission.

likelihood of maladaptive behaviors. One such subject was retested. The results of the second test showed exactly the same personality type and order of phases; the only difference was that the scores were lower. Since these scores were relevant only to the phase for these few individuals, the impact of this problem was not of major importance. The two for which no phase could be determined were eliminated from the relevant analyses.

In the case of the MCMI there were two problems in coding. The first had to do with the fact that a certain amount of translation was necessary (see Figure 2). Most diagnoses on the MCMI translated easily into Process Theory types; others, specifically the Avoidant, Dependent, Narcissistic and Borderline, were more difficult. Dr. Kahler was consulted regarding his thoughts on these translations (personal communication, August 1983). His initial conclusions as to "best fit" were as follows:

Schizoid	Dreamer
Avoidant	Dreamer
Dependent	Reactor
Histrionic.	Reactor
Narcissistic.	Promoter
Antisocial.	Promoter
Compulsive.	Workaholic

MILLON CLINICAL MULTIAXIAL INVENTORY *DSM-III REPORT* FOR PROFESSIONAL USE ONLY

NAME= F 193 VALID REPORT WT. FAC.= -9 15-MAY-84
 CODE=8 6 **2 1 5 * 4 3 + - " 7 //P **//N A D **T H * //PP**//

558 0025

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*****
SCALES * SCORE * PROFILE OF BR SCORES * DSM-III (MILLON)
*RAW BR* 35 60 75 85 100 PARALLELS
*****
[1 [ 18[ 78[XXXXXXXXXXXXXXXXXXXXX ! ! SCHIZOID (ASOCIAL)
+-----+-----+-----+-----+-----+-----+
[2 [ 19[ 82[XXXXXXXXXXXXXXXXXXXXX ! ! AVOIDANT
+-----+-----+-----+-----+-----+-----+
BASIC [3 [ 14[ 60[XXXXXXXXX ! ! DEPENDENT (SUBM:S)
+-----+-----+-----+-----+-----+-----+
PERSONLTY [4 [ 15[ 67[XXXXXXXXXXXXX ! ! HISTRIONIC (GREGAR)
+-----+-----+-----+-----+-----+-----+
PATTERN [5 [ 25[ 76[XXXXXXXXXXXXXXXXXXXXX ! ! NARCISSISTIC
+-----+-----+-----+-----+-----+-----+
[6 [ 23[ 89[XXXXXXXXXXXXXXXXXXXXX ! ! ANTI SOCIAL (AGGRES)
+-----+-----+-----+-----+-----+-----+
[7 [ 17[ 33[XXXXX! ! ! ! ! COMPLISIVE (CONFOR)
+-----+-----+-----+-----+-----+-----+
[8 [ 26[104[XXXXXXXXXXXXXXXXXXXXX P. AGGRES. (NEGAT)
*****
PATHLGCL[S [ 21[ 52[XXXXXXXXX ! ! ! ! SCHIZOTYPAL (SCHIZ)
+-----+-----+-----+-----+-----+-----+
PERSONLTY[C [ 29[ 74[XXXXXXXXXXXXXXXXXXXXX! ! ! BORDERLINE (CYCL)
+-----+-----+-----+-----+-----+-----+
DISORDER[P [ 26[ 97[XXXXXXXXXXXXXXXXXXXXX ! PARANOID
*****

```

MCI narratives have been normed on patients experiencing either genuine emotional discomforts or social difficulties and are applicable primarily during the early phases of assessment or psychotherapy. Distortions such as greater severity may occur among respondents who have inappropriately taken the MCI for essentially educational or self-exploratory purposes. Inferential and probabilistic, this report must be viewed as only one aspect of a thorough diagnostic study. For these reasons, it should not be shown to patients or their relatives.

Figure 2. Printout of Results from the MCI
 (Millon, 1983)
 reprinted by permission

Passive-Aggressive. Rebel
 Schizotypal Dreamer
 Borderline. Cyclers⁴
 Paranoid Persister

For the purposes of this study, these translations were used with the understanding that they are approximations. As Dr. Kahler continued to refine his theory, he referred to the Avoidant, Dependent, Narcissistic and Borderline diagnoses, saying that he believed "[they] are too complicated for a single identification" (personal communication, May, 1984).

The second problem was also identified in the May, 1984 letter. Dr. Kahler stated:

My theory postulates the basic "healthy" structure, and the basic maladaptive behavior for that structure. Any and all other maladaptive behavior under normal stress will correlate to phase, not the basic structure. I see this as a major inconsistency and shortcoming in classical diagnosing. A level 2 or 3 workaholic may be "diagnosed" under differing pressures as being a different structure because this [structure] refers to the 2nd or 3rd degree behaviors. It is much simpler with someone who is level 1 or less; then, the diagnosis matches the basic structure. The higher the level, the more complicated the diagnosis because of phase, and the distress or trauma intensities.

⁴ The term "cyclers" refers to that small percentage of people who alternate between Reactor and Dreamer.

In the context of this study, what this means is that if there happened to be any quite high-functioning people in the clinical sample, they would be misdiagnosed as the personality type of the phase they were in, rather than their basic or primary type. Because of the nature of the clinical subject population, this situation seemed unlikely.

In coding the MCMI results, the diagnostic category that had the highest score was considered to be the personality type. The second highest score was also recorded, but was not codable as a phase.

Hypotheses

The original four research questions were as follows: (1) Can Process Theory produce acceptable interdiagnostic reliability?; (2) Can Process Theory produce acceptable reliability across measures?; (3) Can external validity be demonstrated?; and (4) Can convergent validity with a proven diagnostic instrument be demonstrated?

The hypotheses developed to test these research questions are presented below in the null form.

Hypothesis One

There will be no relationship between judges' clinical assessments of subjects' personality types and phases, according to Process Theory.

Hypothesis Two

There will be no relationship between the judges' clinical assessments of subjects' personality types and phases according to Process Theory, and the assessments of the PPI.

Hypothesis Three

There will be no difference between the normal subjects and the clinical subjects as regards level of functioning assessed by the judges, according to Process Theory.

Hypothesis Four

There will be no relationship between the judges' clinical assessments of subjects' personality types and phases according to Process Theory, and the diagnoses by the MCMI.

Data Analysis

A crucial element in any experimental design is the statistic used. Hall (1974) discusses the choice of a statistic for assessing reliability.

The test of choice for calculating reliability with rating scale should: (1) be distribution free; (2) allow credit for partial rater agreement; (3) correct for rater agreement due to chance alone; (4) make use of individual items in the rating scale; and (5) correct for differences in rater mean scores. One method which appears to meet these criteria satisfactorily is kappa [K] introduced by Cohen (1968). (p. 250)

Others concur in this choice. Grove et al. (1981) say:

Bartko and Carpenter (1976) have reviewed all the major reliability coefficients for psychiatric diagnostic data that had been proposed up to the time of that review. Every one of these coefficients has some mathematical or empirical fault. . . . The task for researchers is to choose the best available coefficient or to devise a better one. Bartko and Carpenter recommend K. . . . Indeed, K is now the most commonly used coefficient for estimating the reliability of a psychiatric diagnosis. (pp. 410-411)

Recent studies confirm Grove's assertion. The kappa statistic or a variation of it called "weighted kappa" (Cohen, 1968; Spitzer, Cohen, Fleiss & Endicott, 1967) has been used in the following diagnostic studies: Acuff, 1981; Cicchetti, 1976; Cloninger, Miller, Wette, Martin and Guze, 1979; Fleiss, Cohen and Everitt, 1969; Mazure and Gershon, 1979; Spitzer, Cohen, Fleiss and Endicott, 1967; Spitzer, Endicott and Robins, 1978; Spitzer and Fleiss, 1974; and Spitzer, Forman and Nee, 1979.

In his original article, Cohen (1960) describes kappa. It is

the proportion of chance-expected disagreements which do not occur, or alternatively, it is the proportion of agreement after chance agreement is removed from consideration. . . . When obtained agreement equals chance agreement, $K=0$. Greater than chance agreement leads to positive values of K, less than chance agreement leads to negative values. The upper limit of K is +1.00, occurring when (and only when) there is perfect agreement between the judges. (pp. 40-41)

It is to be used when "the categories of the nominal scale are independent, mutually exclusive, and exhaustive [and when] the judges operate independently" (p. 38). These descriptions demonstrate that kappa is the statistic of choice for measuring reliability of psychological diagnosis. Since it is a measure of agreement for nominal scales, it is also appropriate for the assessment of convergent validity. Grove et al. (1981) point out the essential similarity of the two assessments. "One ought to measure agreement, not between two raters, but between a rater and the correct diagnosis. This is, in fact, an assessment of validity, not reliability" (p. 410). Cohen himself (1968) said that kappa was "suitable as a measure of validity" (p. 213). Therefore, kappa was used for calculating both reliability and validity.

The kappa coefficient of agreement was appropriate for a sample size of 40 subjects. In similar studies, Mazure and Gershon (1979) used 26 subjects; Spitzer, Endicott and Robins (1978) used 29 in a follow-up study; and Kass, Skodol, Buckley and Charles (1980) used 32. Andreasen and Spitzer (1979) state:

Cicchetti (1976) has recently discussed the issue of sample size in assessments of reliability. When the kappa was originally developed, a rather conservative untested large sample-size estimate of 200 was given by Fleiss, Cohen & Everitt (1969). Cicchetti indicates that this estimate is too high and that the minimal sample size is instead about

20. [In] examining the reliability of a range of mutually exclusive diagnostic categories . . . Cicchetti's reestimate permits investigators to work with samples of a more realistic size and makes the task of determining reliability considerably easier. (p. 383)

The kappa coefficient of agreement was used to assess interdiagnostician agreement among the three experts as to the personality type and level of the subjects, and to assess reliability across measures, that is, the judges' agreement with the PPI. It was also used to assess convergent validity with the MCMI and, by extension, with DSM-III.

The question remains as to the standard to be set for kappa values. Although, as Grove et al. (1981) point out, "No useful statistical test is available to determine when reliability is acceptable," one can "make the simple assumption that a K value of more than 0.5 or 0.6 is acceptable" (p. 412). It is also useful to examine kappa values achieved in recent studies. They are as follows:

Acuff (1981)	k = 0.62	general
Spitzer, Forman & Nee (1979)	k = 0.78	average for joint interviews
	k = 0.66	average for separate interviews
	k = 0.61	joint interviews, personality disorders
	k = 0.54	separate interviews, personality disorders

Spitzer, Endicott &	k = 0.55	depression
Robins (1978)	k = 0.82	mania
	k = 0.58	schizophrenia

Mazure & Gershon (1979)	k = 0.79	general
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Also, Spitzer and Fleiss (1974) reanalyzed the data of two studies using kappa and arrived at the following statistics:

Beck, Ward, Mendelson, Mock & Erbaugh (1962)	k = 0.38-0.47 (range)
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Sandifer, Pettus and Quade (1964)	k = 0.19-0.33 (range)
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As for a "gold standard," Spitzer, Forman and Nee (1979) say that "a high kappa (generally 0.7 and above) indicates good agreement" (p. 816). It is against these figures that this study's results were measured; 0.5 was established as the criterion at which the null hypotheses would be rejected.

CHAPTER IV

RESULTS

Introduction

The original research questions posed in Chapter I concerned the reliability and validity of Process Theory. These questions were developed into four null hypotheses and are presented below with their respective analyses and results.

Hypotheses and Results

Hypothesis One

There will be no relationship between judges' clinical assessments of subjects' personality types and phases, according to Process Theory.

This hypothesis was developed to evaluate inter-diagnostician reliability. In order to test this hypothesis, a kappa coefficient of agreement analysis was conducted. The results of this analysis are shown in Tables 1 and 2.

Table 1
 Agreements of Judges on Personality Type

Judges	Kappa
A & B	0.26
A & C	0.19
B & C	0.32
	$\bar{X} = 0.26^*$

* kappa < 0.5

Table 2
 Agreements of Judges on Personality Type and Phase

Judges	Kappa
A & B	0.13
A & C	0.06
B & C	0.15
	$\bar{X} = 0.11^*$

* kappa < 0.5

The results of this analysis indicated that the null hypothesis could not be rejected.

Hypothesis Two

There will be no relationship between the judges' clinical assessments of subjects' personality types and

phases according to Process Theory, and the assessments by the PPI.

This hypothesis was developed to evaluate inter-measure reliability. In order to test this hypothesis, a kappa coefficient of agreement analysis was conducted. The results of this analysis are shown in Table 3.

Table 3
Agreement of the Judges Assessments with the PPI

Judges	Type	Type & Phase
A & PPI	0.08	0.00
B & PPI	0.24	0.04
C & PPI	0.18	0.05
	$\bar{X} = 0.16^*$	$\bar{X} = 0.03^{**}$

* kappa < 0.5
** kappa < 0.5

The results of this analysis indicated that the null hypothesis could not be rejected.

Hypothesis Three

There will be no difference between the normal subjects and the clinical subjects as regards level of functioning assessed by the judges, according to Process Theory.

This hypothesis was developed to evaluate external validity. (The concept of levels, and the levels that correspond to each phase for the six personality types was described in chapter II.) In order to test this hypothesis, a 1-tailed t-test analysis was conducted. The results of this analysis are shown in Table 4.

Table 4

Judges' Assessments of Subjects' Levels of Functioning

Judges	Average Level of Subjects' Functioning	
	Normal Subjects	Clinical Subjects
A	1.88	1.59
B	1.80	1.28
C	2.00	1.41
	$\bar{X} = 1.89$	$\bar{X} = 1.43$

$p < 0.0005$

The results were significant at the 0.0005 level; therefore the null hypothesis was rejected.

Hypothesis Four

There will be no relationship between the judges' clinical assessments of subjects' personality types and phases according to Process Theory, and the diagnoses by the MCMI.

This hypothesis was developed to evaluate convergent validity. In order to test this hypothesis, a kappa coefficient of agreement analysis was conducted. The results of this analysis are shown in Table 5.

Table 5
Agreements of the Judges Assessments with the MCMI

Judges	MCMI Highest Score
A & MCMI	0.019
B & MCMI	0.104
C & MCMI	0.096
	$\bar{X} = 0.07^*$

* $\text{kappa} < 0.5$

The results of this analysis indicated that the null hypothesis could not be rejected.

Discussion of Results

The analysis of data on interdiagnostician and across measure reliability and on convergent validity revealed that the correlations were not sufficient to allow rejection of hypotheses one, two and four.

In order to test the limits of these evaluations, additional analyses were done. The data were analyzed for "partial rater agreement" (Hall, 1974, p. 250). Regarding hypothesis one, interdiagnostician reliability, the question

questioned might be phrased: "Did the judges agree that a given personality type was present in type or phase?" The results of this analysis using the kappa coefficient of agreement are shown in Table 6.

Table 6

Agreements of Judges that a given Personality Type was Present in Type or Phase

Judges	Kappa
A & B	0.66*
A & C	0.75*
B & C	0.60*
	$\bar{X} = 0.67^*$

* kappa > 0.5

These kappa figures are in the "acceptable" range according to Grove et al. (1981). This could mean that, although the ability to make the subtle differentiation of whether the behavior one sees is a manifestation of type versus phase needs to be improved, the judges were, in fact, frequently recognizing similar processes in the subjects.

The second hypothesis concerned reliability across measures. Here, again, the stricter measures of agreement did not demonstrate acceptable reliability, but the judges did agree often enough with the PPI that a given person-

ality type was present in the type-phase pair that kappas reached acceptable levels. The results of this analysis using the kappa coefficient of agreement are shown in Table 7.

Table 7

Agreements of Judges' Assessments with the PPI that a given Personality Type was Present in Type or Phase

Judges	Kappa
A & PPI	0.67
B & PPI	0.77
C & PPI	0.67
	$\bar{X} = 0.70^*$

* kappa > 0.5

In cases such as these, judges might have assessed subjects as being Workaholics in a Reactor phase, whereas the PPI assessed them as being Reactors in a Workaholic phase. In any case this demonstrates a substantial level of agreement.

The data on external validity, Hypothesis Three, were strikingly conclusive. Subjects could be assessed at level 1 (the lowest level) level 2, or level 3 (signifying a very high level of functioning). People seeking professional help for emotional problems should logically be

functioning at lower levels than people who are not seeking such help. The judges did, in fact, assess the clinical subjects at lower levels than the normal subjects to such an extent that the results were significant at the 0.0005 level. This is despite the fact that they had no prior information differentiating the two groups. One might well conclude that the Process Theory system is excellent for assessing levels of functioning. Therefore hypothesis three was rejected.

The fourth hypothesis dealt with convergent validity with the MCMI. Convergent validity was not demonstrated. Even when the two highest scores on the MCMI were used and searched for any mention in common with the judges' assessments, the kappa correlation (0.3) was not high enough to reject the null hypothesis.

Though not subjected to statistical analyses, various additional observations were made concerning the study's results. These observations may be considered unvalidated preliminary findings. They are described below.

- According to the combined assessments of the judges, the percentages of people in each personality type closely matched those predicted by the theory.
- The MCMI, which was only given to the clinical subjects, vastly overdiagnosed Reactors/Hysterics (55%) and underdiagnosed Workaholics/Obsessive-Compulsives (0%) compared to other measures.

- When the subjects were separated into normal versus clinical, the judges' assessments showed the normal subjects more often in the first three types, whereas the clinical subjects were more often in the last three types.
- When the subjects were separated into male versus female, the judges' assessments closely matched the sex ratios predicted by the theory.
- The MCMI (clinical subjects only) showed more male than female Reactors/Hysterics, which might suggest that such males are over-represented in clinical populations.
- When the subjects were divided into the three age groups, the judges assessed more Workaholics in the over-45 range, and far more Rebels in the 15-19 group. The MCMI concurred in the latter assessment.
- When the subjects are divided into white versus minority, the judges assessed white people more often in the Workaholic, Reactor and Persister categories and minorities most often as Reactors, Rebels and Dreamers.
- When the subjects were divided into educational levels, the judges assessed most subjects with graduate school education as Workaholics. The PPI, on the other hand, assessed them most often as Persisters.
- When the subjects were divided into rural versus urban residents, the judges said that Rebels were 10 times more likely to live in a city. Promoters were also more apt to be urban residents.
- Finally, the judges' abilities to agree with each other were analyzed by personality type using the kappa coefficient of agreement. The results of this analysis are as follows:

Workaholics	0.45
Reactors	0.57
Rebels	0.19
Persisters	0.06
Dreamers	0.40 ⁵
Promoters	0.00 ⁵

⁵ There were so few diagnoses of Promoters that this figure is probably not representative.

CHAPTER V

CONCLUSIONS, IMPLICATIONS & RECOMMENDATIONS

Conclusions

Process Theory is a promising new personality/ diagnostic system that may improve upon certain deficiencies in other current systems. In spite of clearly demonstrated external validity, training to an acceptable level of interdiagnostician and across-measure reliability must be done before this system can be evaluated conclusively. Once this is done, Process Theory may be considered a viable alternative and legitimately compared to other systems.

Implications

There are several implications of these results that should be discussed. It is more than interesting that the judges' assessments matched the theory's predictions as to the relative percentages and sex ratios in each personality type. It is a validation of the relative proportions.

Regarding the low initial reliabilities, most diagnostic systems use intensive training, feedback and supervision to assure adequate interdiagnostician and

inter-measure reliability. The results of this study suggest that Process Theory practitioners could benefit from such training even in the case of people who are experienced clinicians and expert diagnosticians. In the absence of this, it is difficult to assess whether some of the low reliability scores are due to flaws in the system (e.g., inadequate discriminability between type and phase, or inadequate specification of cues) or to a lack of training on the part of the judges. It is also possible that the lack of visual cues unduly hampered the judges, since they had only verbal descriptions of gestures, posture, facial expressions, and appearance. This would imply that the system has certain limitations in its ability to diagnose without personal contact or videotapes of interviews, but still needs to be considered in interpreting the results.

On the other hand, the external validity was so well established that this system might appropriately be considered for use in intake or assessment interviews, at crisis centers, or in other situations where there is a need for rapid assessment of clients' levels of functioning (note that all assessments in this study were made on the basis of a 10-minute interview), especially if training of diagnosticians improved its reliability.

The poor convergent validity data with respect to the

MCMII could be due to a number of factors. The categories may not be similar enough to translate directly. There is also the question of why the MCMII diagnosed no Work-aholics/Obsessive-Compulsives, versus 55% Reactors/Hysterics. It may be that the instrument is more sensitive to one type than the other. There is also a theoretical gap between Process Theory and the MCMII system. Process Theory "postulates the basic 'healthy' structure" (Kahler, personal communication, May, 1984), whereas the MCMII focuses on pathology and is only appropriate for people "experiencing either genuine emotional discomforts or social difficulties" and these primarily during the acute phases of such problems (MCMII results printout, Millon, 1983). The results printout even has warnings which suggest that it may seriously overdiagnose pathology if given to normal subjects. This fundamental difference in theoretical orientation may have been too great for the comparison.

Recommendations

There are certain obvious ways in which studies like this one could be improved. First of all, video-taping all interviews is recommended, as it gives diagnosticians a great deal more information. Using

high quality audio equipment, or even a sound studio, is also suggested. Giving both the PPI and the MCMI to clinical subjects would improve one's ability to assess convergent validity. All the PPI results that noted questionable validity should be investigated and possibly retested to insure the best results.

The recommendations for the use of Process Theory are as follows: A comprehensive program of training, feedback and supervision should be set up for potential diagnosticians, clinicians, or any practitioners to assure a high level of inter-judge and across-measure reliability. Special attention in this training should be given to the subtleties of the type versus phase discrimination, and to the assessment of Rebels, Persisters, and Promoters.

It is recommended that those interested in Process Theory continue to study it. The following are questions for further research.

- Can high levels of inter-judge and across-measure reliability be achieved with training?
- Can convergent validity of the PPI and the MCMI be demonstrated for any diagnostic types?
- Can the results on external validity be replicated?
- Can predictive validity based on level of functioning assessments be demonstrated?

- Can the theoretical predictions of growth through the respective sequences of phases or regression to 1st, 2nd or 3rd degree be validated?
- Do clients improve when the suggested therapy and channel are used?
- Do clients sink to 1st or 2nd degree when they are consistently offered the wrong channel or when their needs are unmet?
- Do therapeutic issues arise in the order predicted?
- Does deterioration or "escalation" occur as predicted?
- Do male Reactors or female Workaholics and Persisters seek psychotherapy more frequently than those of more sex-typical types? Do they experience more emotional distress?
- Do clinical populations have more Dreamers and Promoters than normal populations?
- Are teenagers more frequently assessed as Rebels or diagnosed as Passive-Aggressive?
- Are minorities more apt to be Reactors, Rebels and Dreamers, or are they more apt to be mistakenly assessed as such?
- Are most people in graduate school Workaholics or Persisters, or are these the phases they need to enter in order to succeed in academia?
- Are Rebels and Promoters apt to prefer urban environments?

A good theory generates many testable hypotheses. By this criterion, Process Theory is valuable. And if, after training to acceptable levels of reliability, Process Theory can take its place among other personality/

diagnostic systems, the benefits to the psychological profession could be great indeed.

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APPENDICES

Appendix A
The Informed Consent Forms

INFORMED CONSENT FORM

You are asked to be part of a study. The point of the study is to test a new personality theory. You will be asked some questions about your family and your childhood. This will be taped on a cassette. Then you will be asked to take a short personality test.

Your name will never be used. Instead, we will use a 3-number code to write on your test and on the tape of your interviews. The only people who will see and hear these results will be the experimenter and three professional psychologists, all of whom live outside Massachusetts.

If you are willing to be part of this study, please sign your name.

INFORMED CONSENT FORM FOR SOUTH SHORE MENTAL HEALTH CENTER

You are being asked to be part of a study. The study is a research project for a Doctorate in psychology from Michigan State University. The purpose of the study is to test a new personality theory. You will be asked some questions about your family and your childhood. This will be recorded on a cassette. Then you will be asked to take a personality test.

Your name will never be used. Instead, a number will be used on your test and on the cassette tape. Your responses will be listened to by three psychologists, one from Michigan State University and two from out-of-state.

The test results will be given to your therapist and he will discuss them with you. Your decision to participate in this study, or not, will not affect your treatment in any way. If you decide to participate, you may change your mind and drop out at any time. If you want to hear about the results of the study, I will be glad to explain them to you.

If you are willing to participate, please sign your name in the space below.

(date)

(witness)

Appendix B
The Structured Interview

ChannelQuestions or Statements

2 Hello. Come in. Sit down.

4 I really appreciate your helping me out with
this. You're so nice to do it.

3 I'd like to ask you about some things for a few
minutes. Are you willing to answer some
questions?

5 Whoa, it's kinda weird with this tape going.

4 I'd understand if you felt nervous or whatever.
It's OK to feel however you want here.

5 Are you ready?

3 Will you tell me a little about your family?

2 Start at the beginning. Tell me one of the first
things you remember.

3 Will you describe the place you lived?

5 Sounds like fun!/ Sounds awful!

4 Sounds like you really loved/hated your mother/
father/siblings. I can understand how you
felt.

4 That must have been nice/hard.

3 What did you think about _____?

2 Tell me what you did with your friends.

5 I bet you had a lot of fun!/Boy, that must have
been the pits!

- 4 I bet you do/don't miss them.
- 2 A while ago when you talked about _____ you did
_____.
Tell me about that.
- 3 What do you remember about your grandparents?
- 5 You really lit up/looked bummed when you talked
about them.
- 4 I bet you felt _____. That must have been really
lovely/awful.
- 2 Tell me anything else you want.

Appendix C
The Subject Form

SUBJECT FORM

Number Code _____

Age _____

Sex _____

Race _____

Urban ____ Rural ____

Normal ____ Clinical

Descriptions

Gestures _____

Posture _____

Facial Expressions _____

Dress, Grooming _____

Initiated? _____

Appendix D

The Millon Clinical Multiaxial Inventory

Millon, 1983

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FORM C

MILLON CLINICAL MULTIAXIAL INVENTORY - MCMII

By Theodore Millon, Ph.D.

48868

TEST DIRECTIONS

1. Please fill in the circles that apply in each section on the right side of this page. Do not mark the special section on the lower part of this page; this is for your doctor to complete.
2. Use a soft, black lead pencil only and make a heavy, dark mark when filling in the circles.
3. If you make a mistake or change your mind, please erase the mark fully and then fill in the correct circle.
4. The following pages contain a list of statements that people use to describe themselves. They are printed here to help you in describing your feelings and attitudes. Try to be as honest and serious as you can in marking the statements since the results will be used to help your doctor in learning about your problems and in planning your treatment.
5. Do not be concerned that a few of the statements will seem unusual to you; they are included to describe people with many types of problems. When you agree with a statement or decide that it describes you, fill in the (1) to mark it true (●(1)). If you disagree with the statement or decide that it does not describe you, fill in the (2) to mark it false (○(2)). Try to mark every statement even if you are not sure of your choice. If you have tried your best and still cannot decide, mark the (2) for false.
6. There is no time limit for completing the inventory, but it is best to work as rapidly as is comfortable for you.
7. This form will be scored by computer and the results will be sent directly to your doctor where they will be kept confidential.
8. You may begin with the first statement on the next page after filling in the name grid and information chart on the right side of this page.

COMPLETE ALL INFORMATION BELOW

MARITAL STATUS

Single Married
 Separated Divorced
 Wid. Remarried
 Other

AGE: _____ SEX: Male Female

LAST GRADE COMPLETED

0 () 1 () 2 () 3 () 4 () 5 () 6 () 7 () 8 () 9 ()

10 () 11 () 12 () 13 () 14 () 15 () 16 () 17 () 18 () 19 ()

20 () 21 () 22 () 23 () 24 () 25 () 26 () 27 () 28 () 29 ()

30 () 31 () 32 () 33 () 34 () 35 () 36 () 37 () 38 () 39 ()

40 () 41 () 42 () 43 () 44 () 45 () 46 () 47 () 48 () 49 ()

50 () 51 () 52 () 53 () 54 () 55 () 56 () 57 () 58 () 59 ()

60 () 61 () 62 () 63 () 64 () 65 () 66 () 67 () 68 () 69 ()

70 () 71 () 72 () 73 () 74 () 75 () 76 () 77 () 78 () 79 ()

80 () 81 () 82 () 83 () 84 () 85 () 86 () 87 () 88 () 89 ()

90 () 91 () 92 () 93 () 94 () 95 () 96 () 97 () 98 () 99 ()

What do you feel are the two major problems for which you are seeking help?

1st MAJOR PROBLEMS 2nd

Multiple Personality
 Obs. Compuls. Nerv.
 Schizophrenia
 Mania
 Depression
 Anxiety
 Personality
 Alcoholism
 Drug Abuse
 None

NAME GRID DIRECTIONS

Print your name in the boxes. Print your last name first, as many letters as possible. Then print as much of your first name as possible, and middle initial. Then blacken the circle below each box that has the same letter as the box. Blacken the blank circles for spaces. Use a black lead pencil only.

LAST NAME										FIRST		M
()	()	()	()	()	()	()	()	()	()	()	()	()
(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)
(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)
(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)
(D)	(D)	(D)	(D)	(D)	(D)	(D)	(D)	(D)	(D)	(D)	(D)	(D)
(E)	(E)	(E)	(E)	(E)	(E)	(E)	(E)	(E)	(E)	(E)	(E)	(E)
(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)
(G)	(G)	(G)	(G)	(G)	(G)	(G)	(G)	(G)	(G)	(G)	(G)	(G)
(H)	(H)	(H)	(H)	(H)	(H)	(H)	(H)	(H)	(H)	(H)	(H)	(H)
(I)	(I)	(I)	(I)	(I)	(I)	(I)	(I)	(I)	(I)	(I)	(I)	(I)
(J)	(J)	(J)	(J)	(J)	(J)	(J)	(J)	(J)	(J)	(J)	(J)	(J)
(K)	(K)	(K)	(K)	(K)	(K)	(K)	(K)	(K)	(K)	(K)	(K)	(K)
(L)	(L)	(L)	(L)	(L)	(L)	(L)	(L)	(L)	(L)	(L)	(L)	(L)
(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)
(N)	(N)	(N)	(N)	(N)	(N)	(N)	(N)	(N)	(N)	(N)	(N)	(N)
(O)	(O)	(O)	(O)	(O)	(O)	(O)	(O)	(O)	(O)	(O)	(O)	(O)
(P)	(P)	(P)	(P)	(P)	(P)	(P)	(P)	(P)	(P)	(P)	(P)	(P)
(Q)	(Q)	(Q)	(Q)	(Q)	(Q)	(Q)	(Q)	(Q)	(Q)	(Q)	(Q)	(Q)
(R)	(R)	(R)	(R)	(R)	(R)	(R)	(R)	(R)	(R)	(R)	(R)	(R)
(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)
(T)	(T)	(T)	(T)	(T)	(T)	(T)	(T)	(T)	(T)	(T)	(T)	(T)
(U)	(U)	(U)	(U)	(U)	(U)	(U)	(U)	(U)	(U)	(U)	(U)	(U)
(V)	(V)	(V)	(V)	(V)	(V)	(V)	(V)	(V)	(V)	(V)	(V)	(V)
(W)	(W)	(W)	(W)	(W)	(W)	(W)	(W)	(W)	(W)	(W)	(W)	(W)
(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
(Y)	(Y)	(Y)	(Y)	(Y)	(Y)	(Y)	(Y)	(Y)	(Y)	(Y)	(Y)	(Y)
(Z)	(Z)	(Z)	(Z)	(Z)	(Z)	(Z)	(Z)	(Z)	(Z)	(Z)	(Z)	(Z)

FOR COMPUTER USE ONLY

(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)
(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)
(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)
(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)
(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)
(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)
(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)
(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)
(9)	(9)	(9)	(9)	(9)	(9)	(9)	(9)	(9)	(9)

SPECIAL CODES FOR CLINICIAN OR AGENCY USE ONLY

W	X	Y	Z	P S		I	E	D	T	C O		M S		V	DSM	DX	T S	S S	S R				
(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)
(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)
(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)
(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)
(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)
(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)
(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)
(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)
(9)	(9)	(9)	(9)	(9)	(9)	(9)	(9)	(9)	(9)	(9)	(9)	(9)	(9)	(9)	(9)	(9)	(9)	(9)	(9)	(9)	(9)	(9)	(9)

- 1 I always follow my own ideas rather than do what others expect of me.
- 2 All my life I have worn myself out trying to please other people.
- 3 Talking to other people has almost always been difficult and painful for me.
- 4 I believe in being strong willed and determined in everything I do.
- 5 In the last few weeks I begin to cry even when the slightest of things goes wrong.
- 6 I love to have many different social activities and like to go from one to another.
- 7 I am a very weak person who has to lean on others for almost everything.
- 8 I always feel I am not wanted in a group.
- 9 I often criticize people strongly if they annoy me.
- 10 I am content to be a follower of others.
- 11 I enjoy doing so many different things that I can't make up my mind what to do first.
- 12 I am very changeable in my likes and dislikes.
- 13 I have little interest in making friends.
- 14 I think I am a very sociable and out-going person.
- 15 I know I'm a superior person, so I don't care what people think.
- 16 People have never given me enough recognition for the things I've done.
- 17 I have a drinking problem that I've tried unsuccessfully to end.
- 18 Lately, I get butterflies in my stomach and break out in cold sweats.
- 19 I have always wanted to stay in the background during social activities.
- 20 I will often do things for no reason other than they might be fun.
- 21 I keep my room well organized with everything in the correct place all the time.
- 22 I am the sort of person who changes his opinions and attitudes from day to day.
- 23 There have been times when people have become annoyed with me because I talked too much or too fast for them.
- 24 I'll make a sharp and critical remark to someone if they deserve it.
- 25 I find myself quick to agree with the opinions of others.
- 26 I tend to burst out in tears or in anger for unknown reasons.
- 27 Lately, I've begun to feel lonely and empty.
- 28 I have a talent to be dramatic.
- 29 I have a hard time keeping my balance when walking.
- 30 I enjoy intense competition.
- 31 When I run into a crisis, I quickly look for someone to help me.
- 32 I prefer to be with people who are religious.
- 33 I feel weak and tired much of the time.
- 34 Something exciting always comes along to pull me out of a sad mood.
- 35 My drug habit has often gotten me into a good deal of trouble.
- 36 Lately, I find myself crying without any reason.
- 37 I have always avoided getting involved with people socially.
- 38 Under no circumstances do I ever let myself be tricked by people who say they need help.
- 39 One sure way to make a peaceful world is by improving people's morals.
- 40 I am a very well read person.
- 41 I find it hard to sympathize with people who are always unsure about things.
- 42 I am a very agreeable and submissive person.
- 43 My own "bad temper" has been a big cause of my unhappiness.
- 44 I have always felt a pain somewhere in my body.
- 45 I get very depressed now by even minor things.
- 46 Sometimes my mind goes so fast I can hardly keep up with it.
- 47 I'm so quiet and withdrawn, most people don't even know I exist.
- 48 I like to flirt with members of the opposite sex.
- 49 I am a quiet and fearful person.
- 50 I'm a very erratic person, changing my mind and feelings all the time.
- 51 I feel very tense when I think of the day's happenings.

DO NOT WRITE IN THIS SPACE

- 52 (T) (F) Drinking alcohol on my part has never caused any real problems in my work
- 53 (T) (F) Lately, my strength seems to be draining out of me, even in the morning.
- 54 (T) (F) I've begun to feel like a failure in recent weeks.
- 55 (T) (F) I hate to talk, even to people I know
- 56 (T) (F) I have always had a terrible fear that I will lose the love of people I need very much.
- 57 (T) (F) There have been times when I had so much energy that I didn't need any sleep for days
- 58 (T) (F) Lately, I have begun to feel like smashing things.
- 59 (T) (F) I have given serious thought recently to doing away with myself
- 60 (T) (F) I am always looking to make new friends and meet new people.
- 61 (T) (F) I keep very close track of my money so I am prepared if a need comes up.
- 62 (T) (F) I was on the front cover of several magazines last year.
- 63 (T) (F) Few people like me.
- 64 (T) (F) If someone criticized me for making a mistake, I would quickly point out some of that person's mistakes.
- 65 (T) (F) I often have difficulty making decisions without seeking help from others
- 66 (T) (F) I often let my angry feelings out and then feel terribly guilty about it.
- 67 (T) (F) Lately, I feel jumpy and under terrible strain, but I don't know why.
- 68 (T) (F) I very often lose my ability to feel any sensations in parts of my body.
- 69 (T) (F) When I am home alone I telephone one friend after another just to talk.
- 70 (T) (F) Taking so-called illegal drugs may be unwise, but in the past I found I needed them.
- 71 (T) (F) Lately, I feel tired all the time.
- 72 (T) (F) Lately, I can't seem to sleep, and wake up just as tired as when I went to bed.
- 73 (T) (F) I have a tight feeling in the pit of my stomach every few days or so.
- 74 (T) (F) I used to enjoy performing for family friends when I was younger
- 75 (T) (F) We should respect earlier generations and not think we know better than they.
- 76 (T) (F) I feel terribly depressed and sad much of the time now
- 77 (T) (F) I am the sort of person that others take advantage of
- 78 (T) (F) I always try hard to please others even when I dislike them.
- 79 (T) (F) Serious thoughts of suicide have occurred to me for many years
- 80 (T) (F) I quickly figure out how people are trying to cause me trouble.
- 81 (T) (F) I have periods of so much energy that I can't sit still at all.
- 82 (T) (F) I can't understand it, but I seem to enjoy hurting persons I love
- 83 (T) (F) A long time ago, I decided it's best to have little to do with people.
- 84 (T) (F) I am ready to fight to the death before I'd let anybody take away my self-determination.
- 85 (T) (F) Since I was a child, I have always had to watch out for people who were trying to cheat me.
- 86 (T) (F) When things get boring, I like to stir up some excitement.
- 87 (T) (F) I have an alcoholic problem that has made difficulties for me and my family
- 88 (T) (F) If a person wants something done that calls for real patience, they should ask me.
- 89 (T) (F) I am probably the most creative thinker among the people I know
- 90 (T) (F) I have not seen a car in the last ten years
- 91 (T) (F) I feel I am not a likeable person.
- 92 (T) (F) Punishment never stopped me from doing what I wanted.
- 93 (T) (F) There are many times, when for no reason, I feel very cheerful and full of excitement.
- 94 (T) (F) It would be good for me to be married to a person who is more grownup and less immature than I am
- 95 (T) (F) I very often say things quickly that I regret having said.
- 96 (T) (F) In recent weeks I feel worn out for no special reason
- 97 (T) (F) I feel very guilty lately because I am not able to do things right anymore
- 98 (T) (F) Ideas keep turning over and over in my mind and they won't go away
- 99 (T) (F) I've become quite discouraged and sad about life recently
- 100 (T) (F) Many people have been spying into my private life for years
- 101 (T) (F) I have always gone for long periods when I hardly talk to anyone.
- 102 (T) (F) I hate or fear most people
- 103 (T) (F) I speak out my opinions about things no matter what others may think.
- 104 (T) (F) Sometimes I do things so fast that others get annoyed with me
- 105 (T) (F) My habit of abusing drugs has caused me to miss work in the past
- 106 (T) (F) I am always willing to give in to others to avoid disagreements
- 107 (T) (F) I am often cross and grouchy
- 108 (T) (F) I just don't have the strength lately to fight back.
- 109 (T) (F) Lately, I have to think things over and over again for no good reason
- 110 (T) (F) Looking back on my life, I know I have made others suffer as much as I have suffered
- 111 (T) (F) I use my charm to get the attention of other people
- 112 (T) (F) Though my body pains and problems are real, nobody seems to understand them
- 113 (T) (F) When things scared me as a child, I almost always ran to my mother
- 114 (T) (F) Lately, I've been sweating a great deal and feel very tense
- 115 (T) (F) Sometimes I feel like I must do something to hurt myself or someone else

- 116 (T) (F) I keep so busy doing so many things that people can't figure out what I'll be doing next.
- 117 (T) (F) I've become very jumpy in the last few weeks.
- 118 (T) (F) I keep having strange thoughts that I wish I could get rid of.
- 119 (T) (F) I have a great deal of trouble trying to control an impulse to drink to excess.
- 120 (T) (F) Most people think that I'm a worthless nothing.
- 121 (T) (F) I very often feel a lump in my throat.
- 122 (T) (F) I have succeeded over the years in drinking a minimum of alcohol.
- 123 (T) (F) I have always "tested" people to find out how much they can be trusted.
- 124 (T) (F) Even when I'm awake, I don't seem to notice people who are near me.
- 125 (T) (F) It is very easy for me to make many friends.
- 126 (T) (F) I always make sure that my work is well planned and organized.
- 127 (T) (F) I very often hear things so well that it bothers me.
- 128 (T) (F) If it weren't for the medicines I'm taking, I'd be running around with too much energy in me.
- 129 (T) (F) I don't blame anyone who takes advantage of someone who allows it.
- 130 (T) (F) I am very easily led by people.
- 131 (T) (F) I've many ideas that are ahead of the times.
- 132 (T) (F) Lately, I've been feeling sad and blue and I can't seem to snap out of it.
- 133 (T) (F) I think it is always best to seek help in what I do.
- 134 (T) (F) All my life I have felt guilty for letting down so many people.
- 135 (T) (F) I have always known what my mind tells me and I have never listened to what others say.
- 136 (T) (F) In the last few years, I have felt so guilty that I may do something terrible to myself.
- 137 (T) (F) I never sit on the sidelines when I'm at a party.

- 138 (T) (F) People tell me that I'm a very proper and moral person.
- 139 (T) (F) There have been times recently when I ran around doing so many things at once that I got worn out.
- 140 (T) (F) I have a problem using so-called illegal drugs that has led to family arguments.
- 141 (T) (F) I am very ill-at-ease with members of the opposite sex.
- 142 (T) (F) I have a way of speaking directly that often makes people angry.
- 143 (T) (F) I don't mind that people are not interested in me.
- 144 (T) (F) Frankly, I lie quite often to get out of trouble.
- 145 (T) (F) People can easily change my ideas, even if I thought my mind was made up.
- 146 (T) (F) Others have tried to do me in, but I have the will power to overcome them.
- 147 (T) (F) I often say annoying things without thinking, that hurt someone's feelings.
- 148 (T) (F) I often make people angry by bossing them.
- 149 (T) (F) I have great respect for those in authority over me.
- 150 (T) (F) I have almost no close ties with other people.
- 151 (T) (F) People have said in the past that I became too interested and too excited about too many things.
- 152 (T) (F) I have flown across the Atlantic thirty times in the last year.
- 153 (T) (F) I believe in the saying, "early to bed and early to rise".
- 154 (T) (F) I attempt to be the life of the party.
- 155 (T) (F) I could never be friendly with people who do immoral things.
- 156 (T) (F) My parents always disagreed with each other.
- 157 (T) (F) On occasion I have had as many as ten or more drinks without becoming drunk.
- 158 (T) (F) In social groups I am almost always very self-conscious and tense.

- 159 (T) (F) I think highly of rules because they are a good guide to follow.
- 160 (T) (F) Ever since I was a child, I have been losing touch with the real world.
- 161 (T) (F) I rarely feel anything strongly.
- 162 (T) (F) I have a strong need to depend on others.
- 163 (T) (F) Ideas very often run through my mind much faster than I can speak them.
- 164 (T) (F) Sneaky people often try to get the credit for things I have done or thought of.
- 165 (T) (F) I would really enjoy being in show business.
- 166 (T) (F) I have the ability to be successful in almost anything I do.
- 167 (T) (F) Lately, I have gone all to pieces.
- 168 (T) (F) I have always looked for help in everything I do.
- 169 (T) (F) There has never been any hair on either my head or my body.
- 170 (T) (F) When I am with others I like to be the center of attention.
- 171 (T) (F) I always feel like an outsider in social groups.
- 172 (T) (F) I'm the kind of person who can walk up to anyone and tell him or her off.
- 173 (T) (F) I prefer to be with people who will be protective of me.
- 174 (T) (F) I've had many periods in my life when I was so cheerful and used up so much energy that I fell into a low mood.
- 175 (T) (F) I have had difficulties in the past stopping myself from over using drugs or alcohol.

For Processing
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Appendix E

The Personality Pattern Inventory:

Management and Model Forms

Kahler, 1982a, 1982b

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PROCESS COMMUNICATION MANAGEMENT™

Taibi Kahler, Ph.D.

PERSONALITY PATTERN INVENTORY ITEM BOOKLET

INSTRUCTIONS:

Begin by entering the following information on your computer card. USE A #2 SOFT LEAD PENCIL ONLY.

On front of answer card:

1. Your name— please print.
2. Your organization (company) and department.

On back of answer card:

3. Your name. Be sure to blacken the corresponding grid letter below each letter.
4. Leave columns 4-15 on the back side blank. These are used for computer administrative data.

Be sure to match item numbers on this booklet and the scoring card. Please keep your pencil marks within the space provided. When you erase, do so thoroughly. Bent cards cannot be processed.

Each of the items in this test contains six self-descriptive statements. Darken the "A" square of the statement that "best" describes you. Darken the "B" square of the statement that is the next most descriptive of you. Darken the "C" square of the statement that is next most descriptive. Rank all statements in this fashion as long as they apply directly to you. Leave blank, however, those statements that do not apply directly to you. The sixth choice will be left blank. If one, or several statements do not fit you at all, leave them blank. You need rank, with an "A," the best fit, if that is the only statement that is characteristic of you. Leave the ones that don't fit blank.

SAMPLE: MY FAVORITE DESSERTS INCLUDE

CHOICES (that fit me)						
1st	2nd	3rd	4th	5th		
A	<input checked="" type="checkbox"/>	C	D	E	1. apple pie.	A - Best description
<input checked="" type="checkbox"/>	B	C	D	E	2. cherry pie.	B - Next best description
A	B	C	D	E	3. candy bars.	C - Next best description
A	B	<input checked="" type="checkbox"/>	D	E	4. cabbages.	D - Next best description
A	B	C	<input checked="" type="checkbox"/>	E	5. ice creams.	E - Next best description
A	B	C	D	E	6. fig bars.	

In this sample question, the responder states that he likes cherry pie best (A), apple pie second (B), and cabbages (C), third. He likes ice cream fourth (D). He has no taste at all for fig bars or candy bars and indicates this by leaving these selections blank.

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Management I

MY STRENGTHS ARE MY ABILITIES TO

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|---|
| A | B | C | D | E | 1. nurture and care about others. |
| A | B | C | D | E | 2. play, have fun and be creative. |
| A | B | C | D | E | 3. do tasks that others might find boring. |
| A | B | C | D | E | 4. take in facts and integrate them logically. |
| A | B | C | D | E | 5. focus on a problem that I believe is important and solve it. |
| A | B | C | D | E | 6. adapt, survive and make things happen. |

OF THE FOLLOWING ANIMALS, CO-WORKERS WOULD SEE ME AS

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|---------------|
| A | B | C | D | E | 7. an owl. |
| A | B | C | D | E | 8. a fox. |
| A | B | C | D | E | 9. a cat. |
| A | B | C | D | E | 10. a beaver. |
| A | B | C | D | E | 11. a puppy. |
| A | B | C | D | E | 12. a turtle. |

SOME OF MY COLLEAGUES MIGHT SAY THAT I'M

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|--------------------------------|
| A | B | C | D | E | 13. too sentimental. |
| A | B | C | D | E | 14. too much of a free spirit. |
| A | B | C | D | E | 15. too set in my beliefs. |
| A | B | C | D | E | 16. too work oriented. |
| A | B | C | D | E | 17. too much out for myself. |
| A | B | C | D | E | 18. too shy. |

WHEN THINGS ARE JUST STARTING TO "GO BAD" AT WORK, I TEND TO

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|--|
| A | B | C | D | E | 19. feel that things had been going so smoothly, that I just knew something bad was bound to happen. I guess I didn't do enough to please others. |
| A | B | C | D | E | 20. think that I wasn't perfect enough, or hadn't planned well enough. It seems that I can't enjoy myself or really relax until I work a little longer or harder. I wish co-workers would start thinking more clearly or being more responsible. |
| A | B | C | D | E | 21. believe that co-workers should just think clearly and accept my judgment. I'm usually right, because I'm the one who is logical and rational. I sometimes wonder if my co-workers aren't just trying to "get to me" in some way when things are going bad. |
| A | B | C | D | E | 22. withdraw and seem not to feel or think too much. I don't seem to have the energy to move toward my co-workers and be nurturing or playful or even suggest a plan of action. It might look like I'm hiding inside of myself. |
| A | B | C | D | E | 23. not understand why my co-workers are upset at me. It's difficult for me to accept that it's so important that things "be done so perfectly, kept so orderly," or that there have to be so many "rules." |
| A | B | C | D | E | 24. look to see if some of my co-workers are trying to con me. |

AT MY COFFEE BREAK I TEND TO

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|--|
| A | B | C | D | E | 25. stay by myself and let my mind wander. |
| A | B | C | D | E | 26. seek out a few good friends and enjoy their companionship. |
| A | B | C | D | E | 27. stay by myself and actively plan or review projects that I believe in. |
| A | B | C | D | E | 28. find a bright colleague and share plans and ideas. |
| A | B | C | D | E | 29. find someone else to enjoy me. |
| A | B | C | D | E | 30. get with friends and have some fun. |

IN GENERAL

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|--|
| A | B | C | D | E | 31. when I start something I finish it. |
| A | B | C | D | E | 32. I take directions from others rather than having to start on my own. |
| A | B | C | D | E | 33. I do things for other people that I often don't want to. |
| A | B | C | D | E | 34. I believe you should finish what you start. |
| A | B | C | D | E | 35. the creative, fun stuff is for me. |
| A | B | C | D | E | 36. I can adapt to doing anything if it's worth it to me right away. |

OFTEN I

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|--|
| A | B | C | D | E | 37. act impressed, even when someone is telling me something I already know. |
| A | B | C | D | E | 38. take on more than my share of the work. |
| A | B | C | D | E | 39. have high expectations of others and their performance. |
| A | B | C | D | E | 40. find my own private place to work alone. |
| A | B | C | D | E | 41. get bored with routines and rules. |
| A | B | C | D | E | 42. feel that I could sell just about anything to anybody. |

WHEN THINGS ARE "REALLY GOING BADLY" AT WORK, I TEND TO

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|--|
| A | B | C | D | E | 43. figure that I'm not going to be on the short end of the stick. I don't want to let guilt or remorse get in my way and let someone con me. |
| A | B | C | D | E | 44. feel confused or inadequate and sometimes make silly mistakes. I then feel punished and rejected by my supervisor or co-workers. |
| A | B | C | D | E | 45. feel frustrated with people for acting so "stupid". I seem to be particularly upset about money matters, the office being messy and dirty, or others not doing their fair share of work. |
| A | B | C | D | E | 46. feel frustrated at people for not fulfilling their responsibilities. I start to question to myself other's motives and behaviors. |
| A | B | C | D | E | 47. withdraw and shut down. It's as if this is happening to someone else, not me. |
| A | B | C | D | E | 48. get the blame, get mad about it, and secretly think, "I'll show you". |

A SAYING FOR ME COULD BE

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|---|
| A | B | C | D | E | 49. "It's better to give than to receive." |
| A | B | C | D | E | 50. "Work now, play later." |
| A | B | C | D | E | 51. "A person without beliefs is a person without purpose." |
| A | B | C | D | E | 52. "Don't make waves." |
| A | B | C | D | E | 53. "Do your own thing." |
| A | B | C | D | E | 54. "Look out for number one." |

I PREFER

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|-----------------|
| A | B | C | D | E | 55. intimacy. |
| A | B | C | D | E | 56. ideas. |
| A | B | C | D | E | 57. values. |
| A | B | C | D | E | 58. fun things. |
| A | B | C | D | E | 59. excitement. |
| A | B | C | D | E | 60. privacy. |

AN IDEAL WORK RELATIONSHIP FOR ME IS TO HAVE A CO-WORKER WHO

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|--|
| A | B | C | D | E | 61. likes to do fun, spontaneous, and playful things with me. |
| A | B | C | D | E | 62. can handle being on the "fast track" and who likes excitement—
who'll follow my lead knowing that I'm a high risk person. |
| A | B | C | D | E | 63. is warm, nurturing, and caring—someone who cares about me
and how I feel. |
| A | B | C | D | E | 64. respects my opinions. |
| A | B | C | D | E | 65. allows me my own space and time and respects my privacy. |
| A | B | C | D | E | 66. recognizes the hard work I do for the organization and also that
I am responsible and plan my time well. |

I TEND TO DRESS

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|---|
| A | B | C | D | E | 67. with what I have left in the closet and with what the weather
"dictates." If it's cold, I'll put on a warm sweater. It doesn't matter
if my socks don't match. |
| A | B | C | D | E | 68. casually, or the way my crowd does. I'm not a "socie" or a
"preppie" who dresses to impress. I like my independence and
and being different. |
| A | B | C | D | E | 69. in bright colors. I like expensive looking clothes and jewelry. I may
wear my shirt or blouse open. When I've got money, I want the
best clothes. If you got it, flaunt it! |
| A | B | C | D | E | 70. in soft colors. I like jewelry, I want my face to look its best and
I like my hair to be in an attractive style. I also find certain per-
fumes or colognes particularly enjoyable. |
| A | B | C | D | E | 71. in a tidy, neat, clean manner. Pressed clothes and shined shoes
would be nice. I generally have a business-like appearance. |
| A | B | C | D | E | 72. in a basically conservative fashion that generally fits with what
a person should wear in his or her organization or work. |

IN GENERAL, I HAVE PREFERRED

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|---|
| A | B | C | D | E | 73. being alone with my fantasies, daydreams, or using my imagination. Sometimes, I prefer doing things that don't require lots of energy thinking all the time. |
| A | B | C | D | E | 74. being with my friends and doing our thing, even though others may not approve or understand. |
| A | B | C | D | E | 75. to live life for today, I'm basically a loner who knows that a nine-to-five existence is not for me. |
| A | B | C | D | E | 76. being with people and especially feeling wanted, accepted, and important when I'm in a group. |
| A | B | C | D | E | 77. either being alone and thinking or planning, or being with one other person in a stimulating, intellectual or thought-provoking discussion. |
| A | B | C | D | E | 78. either being alone and thinking, organizing or philosophizing, or being with one other person, sharing beliefs, opinions or views on politics, religion, or current events. |

THE SUPERVISOR I PREFER IS ONE WHO

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|--|
| A | B | C | D | E | 79. tells me what to do, when to have it done, and leaves me alone to do it. |
| A | B | C | D | E | 80. is warm, supportive, and considers my feelings. |
| A | B | C | D | E | 81. is playful and encourages my creativeness. |
| A | B | C | D | E | 82. is fair with me and recognizes my accomplishments.. |
| A | B | C | D | E | 83. gives me a free hand to "wheel and deal." |
| A | B | C | D | E | 84. clearly defines my job and entrusts me with the authority to carry it out. |

I BELIEVE THAT

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|---|
| A | B | C | D | E | 85. I can't enjoy myself until I finish my work. |
| A | B | C | D | E | 86. there is always someone who keeps me from having a good time. |
| A | B | C | D | E | 87. when things look the brightest, watch out for a storm. |
| A | B | C | D | E | 88. not everybody wants to be a "chief". |
| A | B | C | D | E | 89. you're a fool if you go around trusting people. |
| A | B | C | D | E | 90. you should work first, prove your loyalty, and then take time to rest and play. |

THE THINGS I WOULD GIVE UP LAST ARE

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|-----------------------|
| A | B | C | D | E | 91. warmth. |
| A | B | C | D | E | 92. knack for fun. |
| A | B | C | D | E | 93. logical mind. |
| A | B | C | D | E | 94. beliefs. |
| A | B | C | D | E | 95. alone time. |
| A | B | C | D | E | 96. ability to adapt. |

WHAT I NEED MOST FROM MY WORK IS

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|--|
| A | B | C | D | E | 97. to feel appreciated as a person by my co-workers. |
| A | B | C | D | E | 98. some unstructured time to play, joke and flap my wings a little. |
| A | B | C | D | E | 99. enough authority to put my ideas to work for the organization. |
| A | B | C | D | E | 100. a car, an expense account, and immediate compensation. |
| A | B | C | D | E | 101. respect and admiration for my opinions and a "cause" to work for. |
| A | B | C | D | E | 102. regular working hours, my own private space, and time for me. |

I WOULD PREFER MY OFFICE OR HOME TO BE

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|---|
| A | B | C | D | E | 103. a place where I enjoy myself. I'd have posters, art works, games for people, and maybe collections of fun things. |
| A | B | C | D | E | 104. expensive looking with thick carpets and fancy furniture. I like bright colors like reds and blacks, and would want people to be impressed that I had "made it." |
| A | B | C | D | E | 105. warm and cozy. My "nest" is important to me. |
| A | B | C | D | E | 106. functional, organized and tidy. Things have their place and I like them there, and clean. Degrees, diplomas, or pictures should be hung symmetrically and kept in place. |
| A | B | C | D | E | 107. organized and functional. An environment that has a traditional flavor and a certain cultured, cosmopolitan, or sophisticated atmosphere. |
| A | B | C | D | E | 108. a place to work or live. I'd prefer a place more to myself, out of the flow of traffic. |

WHEN THINGS GO WRONG I

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|--|
| A | B | C | D | E | 109. withdraw and shut down. |
| A | B | C | D | E | 110. end up catching the blame. |
| A | B | C | D | E | 111. get angry with whoever isn't thinking clearly or doing his/her share. |
| A | B | C | D | E | 112. get upset and want someone to "make things alright". |
| A | B | C | D | E | 113. look out for number one. |
| A | B | C | D | E | 114. dig in and hold firm with my beliefs. |

IF I DIDN'T WATER A PLANT THAT WAS MY RESPONSIBILITY, I WOULD PREFER MY SUPERVISOR'S SAYING

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|---|
| A | B | C | D | E | 115. "will you tell me what your plans are for watering the plants? I am not knowledgeable and respect your opinion." |
| A | B | C | D | E | 116. "Did you ever hear of the 'Thirsty Plant' that devoured Metropolis?" |
| A | B | C | D | E | 117. "Hey, I know plants aren't your scene. We'll get something going for you soon. In the meantime, water the plants once a week." |
| A | B | C | D | E | 118. "I appreciate how well you take care of us and look after the office. I know it takes a lot of energy and we're glad you're here." |
| A | B | C | D | E | 119. "I understand that we have 15 plants in our offices. Since you have effectively managed other office maintenance, will you add the care of these plants to your schedule?" |
| A | B | C | D | E | 120. "You didn't water the plant. Please water it by 4:00." |

Management 6

AT WORK I WOULD RATHER BE

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|---|
| A | B | C | D | E | 121. given a task to do alone. |
| A | B | C | D | E | 122. surrounded by friends. |
| A | B | C | D | E | 123. involved in the creative, less structured part of the project. |
| A | B | C | D | E | 124. requested to structure and organize projects. |
| A | B | C | D | E | 125. given a project that requires stick-to-it-iveness and that will be impactfull. |
| A | B | C | D | E | 126. paid a commission than work nine-to-five. |

I

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|---|
| A | B | C | D | E | 127. live for today. Opportunities are to be made and taken advantage of. |
| A | B | C | D | E | 128. would rather form close relationships than collect awards. |
| A | B | C | D | E | 129. put off having fun until I reach my goals. |
| A | B | C | D | E | 130. have not changed significant goals in years. |
| A | B | C | D | E | 131. daydream about my goals and share them with very few. |
| A | B | C | D | E | 132. prefer to play first, then work. |

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PROCESS COMMUNICATION MODEL™

REVISED

Taibi Kahler, Ph.D.

PERSONALITY PATTERN INVENTORY ITEM BOOKLET

INSTRUCTIONS:

Begin by entering the following information on your computer card. USE A #2 SOFT LEAD PENCIL ONLY.

On front of answer card:

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2. Your organization (company) and department.

On back of answer card:

3. Your name. Be sure to blacken the corresponding grid letter below each letter.
4. Leave columns 4-15 on the back side blank. These are used for computer administrative data.

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SAMPLE: MY FAVORITE DESSERTS INCLUDE

CHOICES (that fit me)

1st	2nd	3rd	4th	5th	
A	<input checked="" type="checkbox"/>	C	D	E	1. apple pie.
<input checked="" type="checkbox"/>	B	C	D	E	2. cherry pie.
A	B	C	D	E	3. candy bars.
A	B	<input checked="" type="checkbox"/>	D	E	4. cabbages.
A	B	C	<input checked="" type="checkbox"/>	E	5. ice creams.
A	B	C	D	E	6. fig bars.

A - Best description
B - Next best description
C - Next best description
D - Next best description
E - Next best description

In this sample question, the responder states that he likes cherry pie best (A), apple pie second (B), and cabbages (C), third. He likes ice cream fourth (D). He has no taste at all for fig bars or candy bars and indicates this by leaving these selections blank.

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THE MOST VALUABLE PARTS OF MY PERSONALITY ARE THOSE THAT

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|--|
| A | B | C | D | E | 1. show sensitivity and respond to the feelings of others. |
| A | B | C | D | E | 2. have flexibility, creativity and a joy for life. |
| A | B | C | D | E | 3. I let few people look into. |
| A | B | C | D | E | 4. give and take information and organize it. |
| A | B | C | D | E | 5. have high ideals, morals, and expectations. |
| A | B | C | D | E | 6. find clever ways of taking care of myself. |

I PREFER TO BE WITH FRIENDS WHO

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|---|
| A | B | C | D | E | 7. respect my beliefs and principles. |
| A | B | C | D | E | 8. like excitement and want to have a good time. |
| A | B | C | D | E | 9. are active, fun, and do their own thing. |
| A | B | C | D | E | 10. provide a lively exchange of interesting ideas. |
| A | B | C | D | E | 11. are warm and accepting. |
| A | B | C | D | E | 12. respect my privacy. |

AFTER ARGUING, I AM LIKELY TO EXPERIENCE

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|---|
| A | B | C | D | E | 13. feeling hurt or rejected. |
| A | B | C | D | E | 14. "I'll show you". |
| A | B | C | D | E | 15. the other person still not accepting my views. |
| A | B | C | D | E | 16. frustration at someone else's irresponsibility. |
| A | B | C | D | E | 17. nothing, if there are no real consequences. |
| A | B | C | D | E | 18. myself withdrawing and being alone. |

AN IDEAL RELATIONSHIP FOR ME WOULD BE TO HAVE A FRIEND WHO

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|---|
| A | B | C | D | E | 19. is warm, nurturing, and caring—someone who cares about me and how I feel. |
| A | B | C | D | E | 20. recognizes the hard work I do, how responsible I am, and how well I plan my time. |
| A | B | C | D | E | 21. respects my opinions and believes in me and my values. |
| A | B | C | D | E | 22. allows me my own space and time and respects my privacy. |
| A | B | C | D | E | 23. likes to do fun, spontaneous and playful things with me. |
| A | B | C | D | E | 24. can handle being on the "fast track," and who likes excitement—
who'll follow my lead knowing that I'm a high risk person. |

Model 2

WHEN THINGS GO BAD I

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|---|
| A | B | C | D | E | 25. go off by myself and seem not to feel much. |
| A | B | C | D | E | 26. feel unloved or rejected. |
| A | B | C | D | E | 27. dig in and hold firm with my beliefs. |
| A | B | C | D | E | 28. push others away verbally. |
| A | B | C | D | E | 29. look out for number one. |
| A | B | C | D | E | 30. feel hurt, and often vengeful. |

AS A CHILD I

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|--|
| A | B | C | D | E | 31. was the eldest or the only child (or was treated as if I were). I had to be the responsible one. I learned early on to work hard and play later. As I think about it, I don't remember much about my early childhood. |
| A | B | C | D | E | 32. was withdrawn and shy. I discovered I could use my imagination and daydreams. I did things by myself, or was overtaken care of by an other brother or sister. |
| A | B | C | D | E | 33. enjoyed belonging in the family and wanted to be loved and nurtured by my father especially. Anger was something that wasn't supposed to show. To this day, when I'm angry I tend to cry or smile. |
| A | B | C | D | E | 34. had a stern parent who instilled in me strong beliefs and convictions. I learned how important a good education was. I got little emotional nurturing and remember feeling frightened some, until I got older. |
| A | B | C | D | E | 35. liked animals, loved to play and have fun, but got bored easily. Later on my parents seemed to hassle me about having to be so responsible about things- like complaining that I didn't do my chores or that my room was "always messy". |
| A | B | C | D | E | 36. came from a family that wasn't that close. I sometimes thought that I didn't belong. I was pretty much on my own to make it. I liked to play "war" and became streetwise real early. |

THE PART(S) OF MY PERSONALITY THAT I SEEM TO USE A LOT ARE

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|--|
| A | B | C | D | E | 37. a concerned, nurturing, taking-care-of-others part. |
| A | B | C | D | E | 38. a clear thinking, logical one. |
| A | B | C | D | E | 39. a logical, thinking one with some emphasis on values, opinions, and judgments. |
| A | B | C | D | E | 40. an imaginative one. I tend to let my mind drift in time and space. |
| A | B | C | D | E | 41. a fun, playful, sometimes very active one. |
| A | B | C | D | E | 42. a clever one that I have learned to use to get me out of tight spots. Sometimes, I need to be tough, sometimes charming. |

Model 3

I PREFER

CHOICES (that fit me)					
1st	2nd	3rd	4th	5th	
A	B	C	D	E	43. excitement.
A	B	C	D	E	44. people.
A	B	C	D	E	45. ideas.
A	B	C	D	E	46. values.
A	B	C	D	E	47. privacy.
A	B	C	D	E	48. fun things.

OF THE FOLLOWING, THE ONES THAT FIT FOR ME ARE

CHOICES (that fit me)					
1st	2nd	3rd	4th	5th	
A	B	C	D	E	49. "Why am I the one to get rejected?"
A	B	C	D	E	50. "I try to be responsible. I even take on more than my share."
A	B	C	D	E	51. "Without morals and ethics, people are dangerous."
A	B	C	D	E	52. "I seem to be the one always left out."
A	B	C	D	E	53. "I'll show you; it's not always my fault."
A	B	C	D	E	54. "P.T. Barnum was right, there are two kinds of people in this world - fools, and people who make fools of fools, and I don't really trust too many people."

I WOULD PREFER MY WORK AREA OR HOME TO BE

CHOICES (that fit me)					
1st	2nd	3rd	4th	5th	
A	B	C	D	E	55. warm and cozy, with soft earth colors. My "nest" is important to me. The smell of candles and flowers, the comfortable furniture, and pleasant music are important to me.
A	B	C	D	E	56. functional, organized, and tidy. Things have their place and I like them there, and clean. Awards, diplomas, or pictures should be hung symmetrically and kept in place.
A	B	C	D	E	57. organized and functional. An environment that has a traditional flavor and a certain cultured, cosmopolitan, or sophisticated atmosphere.
A	B	C	D	E	58. a place where I enjoy myself. I'd have posters, art works, games for people, and maybe collections of fun things.
A	B	C	D	E	59. expensive looking with thick carpets and fancy furniture. I like bright colors like reds and blacks, and would want people to be impressed that I could afford this and that I had "made it."
A	B	C	D	E	60. a place to work or live. My environment is not that important to me, so I wouldn't take all that effort to have fresh flowers or candles. I'd prefer a place more to myself, out of the flow of traffic.

USUALLY, I

CHOICES (that fit me)					
1st	2nd	3rd	4th	5th	
A	B	C	D	E	61. try to do my share, but "boring is boring."
A	B	C	D	E	62. hide what I'm feeling.
A	B	C	D	E	63. try to please almost everyone.
A	B	C	D	E	64. have high expectations for other people.
A	B	C	D	E	65. experience myself in a shell-like world.
A	B	C	D	E	66. am driven to excel and achieve.

Model 4

IN GENERAL, I HAVE PREFERRED

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|--|
| A | B | C | D | E | 67. being alone with my fantasies, daydreams, or using my imagination. Sometimes, I prefer doing things that don't require lots of energy thinking all the time. |
| A | B | C | D | E | 68. being with my friends and doing our thing, even though others may not approve or understand. |
| A | B | C | D | E | 69. to live life for today. I'm basically a loner who knows that a nine-to-five existence is not for me. |
| A | B | C | D | E | 70. being with people and especially feeling wanted, accepted, and important when I'm in a group. |
| A | B | C | D | E | 71. either being alone and thinking or planning, or being with one other person in a stimulating, intellectual or thought-provoking discussion. |
| A | B | C | D | E | 72. either being alone and thinking, organizing or philosophizing, or being with one other person, sharing beliefs, opinions, or views on politics, religion, or current events. |

PEOPLE KNOW THAT I LIKE THEM BY MY

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|---|
| A | B | C | D | E | 73. respecting their privacy and alone time. |
| A | B | C | D | E | 74. playing and having fun. |
| A | B | C | D | E | 75. trusting them to do something "big" and exciting with me. |
| A | B | C | D | E | 76. being warm, close, and caring. |
| A | B | C | D | E | 77. planning, thinking, and working hard. |
| A | B | C | D | E | 78. having values, and being loyal and devoted. |

I SOMETIMES EXPERIENCE

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|--|
| A | B | C | D | E | 79. myself withdrawing into a shy, shell-like appearance. It's as if I'm in a world all by myself. |
| A | B | C | D | E | 80. myself wanting to please others in hopes of being accepted. Sometimes I have a hard time saying "no" or putting myself first. |
| A | B | C | D | E | 81. others being upset at me. It's difficult for me to accept that things "be done so perfectly" or that there have to be so many "rules". |
| A | B | C | D | E | 82. putting lots of pressure on myself to be perfect in order not to make mistakes, or in order that others will understand me just right. I often over-qualify or need to explain myself. |
| A | B | C | D | E | 83. having to be strong. If I don't look after me, who will? Making a relationship means that the other person will go with the program and do what needs to be done. Opportunities are made to take advantage of. |
| A | B | C | D | E | 84. myself believing in something, or having a strong conviction or opinion. |

Model 5

MY STRENGTHS ARE MY ABILITIES TO

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|--|
| A | B | C | D | E | 85. receive and process information to solve problems. |
| A | B | C | D | E | 86. play, have fun, and be creative. |
| A | B | C | D | E | 87. nurture and care about others. |
| A | B | C | D | E | 88. do tasks others might find boring. |
| A | B | C | D | E | 89. adapt, survive, and make things happen. |
| A | B | C | D | E | 90. stick with my beliefs, even under pressure. |

IN IMPORTANT FRIENDSHIPS IN THE PAST WHEN THERE WAS AN UNPLEASANT ENDING, I

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|--|
| A | B | C | D | E | 91. just wanted to please my friend, but it seemed the more I gave, the less I got. I ended up feeling rejected and unloved. |
| A | B | C | D | E | 92. tried to make things fun. The more I tried, the more I got criticized. I felt hurt and angry at being rejected and ignored. |
| A | B | C | D | E | 93. got tired of the demands on me and my time after I had worked hard all day and been responsible enough to meet my obligations. I would get frustrated and even lost my temper occasionally. |
| A | B | C | D | E | 94. couldn't seem to convince my friend how important some things in life are - having goals, commitments, or strong beliefs by which to live. I'd even find myself "preaching" sometimes. |
| A | B | C | D | E | 95. couldn't seem to express what was going on inside of me. I've had difficulty even with closest friends making lively conversation. The more my friends expected me to be involved and outgoing, the more I seemed to withdraw. |
| A | B | C | D | E | 96. was smart enough to know to move on before my time was up. I would not get so wrapped up with somebody to where I could be the one dropped. |

SOME OF MY FRIENDS MIGHT SAY THAT I'M TOO

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|----------------------------|
| A | B | C | D | E | 97. sentimental. |
| A | B | C | D | E | 98. much of a free spirit. |
| A | B | C | D | E | 99. work oriented. |
| A | B | C | D | E | 100. manipulative. |
| A | B | C | D | E | 101. set in my beliefs. |
| A | B | C | D | E | 102. shy. |

AT WORK I WOULD RATHER BE

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|---|
| A | B | C | D | E | 103. involved in the creative, less structured part of the project. |
| A | B | C | D | E | 104. he paid a commission than work nine-to-five. |
| A | B | C | D | E | 105. surrounded by friends. |
| A | B | C | D | E | 106. requested to structure and organize projects. |
| A | B | C | D | E | 107. given a project that requires stick-to-it-iveness and that will be impactfull. |
| A | B | C | D | E | 108. given a task to do alone, but with lots of directions. |

Model 6

OFTEN I

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|--|
| A | B | C | D | E | 109. find my own private place to be. |
| A | B | C | D | E | 110. get bored with routines, and have to get some stimulation. |
| A | B | C | D | E | 111. take on more responsibility than I need to. |
| A | B | C | D | E | 112. act impressed, even when someone is telling me something I already know. |
| A | B | C | D | E | 113. feel that I could sell or convince somebody of just about anything I wanted to. |
| A | B | C | D | E | 114. have high expectations of others and their performance. |

A SAYING FOR ME COULD BE

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|---|
| A | B | C | D | E | 115. "Stick to it and trust in your beliefs." |
| A | B | C | D | E | 116. "Do your own thing." |
| A | B | C | D | E | 117. "Look out for number one." |
| A | B | C | D | E | 118. "It's better to give than to receive." |
| A | B | C | D | E | 119. "Work now, play later." |
| A | B | C | D | E | 120. "Don't make waves." |

OF THE FOLLOWING ANIMALS, FRIENDS WOULD SEE ME AS

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|----------------|
| A | B | C | D | E | 121. a turtle. |
| A | B | C | D | E | 122. a puppy. |
| A | B | C | D | E | 123. a cat. |
| A | B | C | D | E | 124. a beaver. |
| A | B | C | D | E | 125. an owl. |
| A | B | C | D | E | 126. a fox. |

I WOULD GIVE UP LAST MY

CHOICES (that fit me)

- | 1st | 2nd | 3rd | 4th | 5th | |
|-----|-----|-----|-----|-----|------------------------|
| A | B | C | D | E | 127. ability to adapt. |
| A | B | C | D | E | 128. warmth. |
| A | B | C | D | E | 129. clear thinking. |
| A | B | C | D | E | 130. beliefs. |
| A | B | C | D | E | 131. alone time. |
| A | B | C | D | E | 132. knack for fun. |

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Model 7

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Appendix F
Preliminary Analyses of the PPI

Personality Pattern Inventory
Validation Procedures

As the Personality Pattern Inventory (PPI) was first conceived, the following five elements germane to experimental design construction were considered:

1. A set of questions is administered to each participant in a structured manner to ensure that the method of administration remains consistent across different persons giving and taking the inventory.
2. The responses to the inventory are considered to be a sample of his or her behavior.
3. A number is assigned to each response so that inferences can be drawn about the participant's possession of the variable or traits presumably measured by the inventory.
4. Objective measures must be taken in the assigning of numerals, and in inferring the quantity of the trait possessed.
5. Reliability and validity measures must be determined by objective, empirical procedures.

Two key words in understanding the essence of good empirical design are reliability and validity. Reliability means accuracy. Procedures for determining reliability are procedures for measuring the accuracy of a test--in other words, the degree to which a participant's inventory score reflects his Personality Type, rather than effects of error.

Validity addresses the question, "Does the inventory yield the information that it was designed to?"

Face, concurrent, and predictive validity are all relevant to the PPI. Face validity refers to the participant's impression that the PPI measures what he or she thinks, feels, or believes that it did.

Concurrent validity refers to the focus of the inventory to produce an assessment of the participant into one of the six Personality Types. Predictive validity refers to the predicting of the participant whether or not he or she will develop a criterion-state, such as a given Failure Pattern, or new, open Channel of Communication.

The following steps and procedures were carried out in the development of the PPI:

In psychology and psychiatry clinical diagnostic categories are used to identify clusters of maladaptive behavior patterns in order to understand the underlying dynamics and to determine a treatment plan.

Trained "experts," usually psychologists and psychiatrists, are called on to use their clinical skills of observation and evaluation to diagnose a person (i.e., give a name to the maladaptive behavior pattern that has been officially defined and described in the Diagnostic and Statistical Manual III). Such widely used tests as the Minnesota Multiphasic Personality Inventory are often administered to determine diagnoses.

In the spirit of Shapiro (1969) personality styles were considered, where not just maladaptive behaviors were addressed, but rather the complementary positive behaviors as well.

Following Ware's (1978) theory of personality adaptations, six Personality Types were identified: Reactor, Workaholic, Persister, Dreamer, Rebel and Promoter. With Kahler's (1978) theory of Process Therapy, positive patterns of behavior were associated with each Personality Type, yielding both positive and negative (maladaptive) behavior patterns.

Three "experts" in assessing the six Personality Types independently interviewed 100 people. All six Personality Types were represented in the sample. All three judges agreed on 97 assessments: A and B on 98, A and C on 97, and B and C on 99, thus yielding high interjudge reliability (significant at 0.001).

An additional number of people were assessed and selected by the judges independently so that a minimum number of 30 persons were available for each classification of Personality Type, yielding a total sample of 180 identified "assessed" people.

Two hundred and thirteen items were administered to 112 subjects randomly selected. Analysis of this data indicated a "natural" loading on six criteria--the six Personality Types.

The same 213 items were administered to the 180 identified Personality Types. Only items with a correlation of greater than 0.60 were accepted for inclusion in the final Personality Pattern Inventory.

Two forms of the PPI were constructed from these significant items. Both forms have twenty-two items, with six answers each to be ranked by the participant. This yields a score on each of the Personality Type scales. The following correlations are reported for items and scales for each form:

KENDALL CORRELATIONS

Original Items	PCM 1 2	Reactors	Worka- holics	Promoters	Rebels	Persisters	Dreamers	- X
1.	X	.89	.77	.44	.77	.54	.72	.69
2.	X	.96	.94	.62	.79	.65	.85	.80
3.	X X	.67	.95	.83	.88	.77	.64	.79
4.	X	.93	.85	.59	.56	.42	.72	.68
5.	X X	.95	.80	.70	.78	.76	.76	.79
6.	X	.67	.88	.64	.56	.54	.76	.68
7.	X X	.54	.95	.87	.82	.55	.72	.81
8.	X	.82	.91	.70	.72	.67	.75	.76
9.	X	.64	.92	.54	.62	.60	.76	.68
10.	X	.97	.94	.76	.83	.62	.52	.77
11.	X X	.79	.75	.81	.75	.61	.72	.74
12.	X	.66	.77	.83	.62	.58	.76	.70
13.	X	.95	.92	.82	.62	.50	.86	.78
14.	X X	.99	.78	.74	.72	.75	.71	.76
15.	X	.93	.68	.62	.65	.73	.90	.75
16.	X X	.99	.84	.48	.83	.51	.66	.72
17.	X X	.90	.71	.75	.71	.66	.90	.77
18.	X	.64	.94	.53	.71	.91	.65	.73
19.	X X	.95	.91	.85	.74	.51	.63	.77
20.	X	.96	.71	.64	.70	.64	.88	.76
21.	X	.79	.94	.50	.75	.51	.74	.71
22.	X X	.96	.68	.77	.72	.66	.57	.73
23.	X X	.54	.73	.88	.60	.70	.66	.69
24.	X	.74	.84	.62	.62	.40	.71	.66
25.	X	.60	.89	.57	.45	.66	.64	.64
26.	X	.64	.58	.72	.64	.56	.58	.62
27.	X	.78	.57	.75	.72	.70	.70	.70
28.	X	.66	.94	.70	.50	.62	.57	.67
29.	X	.60	.66	.85	.65	.62	.57	.66
30.		.42	.70	.77	.54	.75	.87	.68
31.	X	.64	.77	.72	.74	.75	.77	.73
32.	X	.94	.85	.65	.40	.62	.58	.67
JJ.	X	.70	.64	.55	.57	.79	.40	.61
34.	X X	.56	.73	.81	.47	.63	.76	.66

KENDALL CORRELATIONS

N=20 for each		Reactors	Worka- holics	Promoters	Rebels	Persisters	Dreamers
PCM ₁	\bar{X} 's:	.80	.79	.71	.69	.64	.70
PCM ₂	\bar{X} 's:	.82	.83	.72	.69	.63	.70
PPI(1&2) \bar{X} 's:		.81	.81	.72	.69	.63	.70
PCM ₁	$\bar{X} = .72$						
PCM ₂	$\bar{X} = .73$						
PPI(1&2) $\bar{X} = .73$ Significant at .001 level							

Further research will produce even more accurate items.

Each form of the PPI is designed to prevent a participant from endorsing socially desirable items (fake good) and from endorsing socially unusual or uncommon responses (fake bad).

By examining the responses relative to the normal characteristics of each Personality Type scale, a "questionable validity" comment may be assigned. Interview techniques by experts in Process Communication could also determine this.

Relative Manager Scores and Relative Interaction Scores for all six Personality Types are recorded and statistical procedures are performed to help determine usefulness.

Research of demographics is currently being conducted. Also, various management experimental designs are being conducted. For example, a psychologist at Northwestern University is measuring "teller mistakes" at a bank. After matching and getting baseline data on the tellers, one group of supervisors will receive no instruction, and another group of supervisors will receive information about their tellers' Personality Types. The Process Communication material will be taught to them, including an understanding of their own Personality Type, through their PPI's. After a period of time a post test will be given both the control and experimental groups to determine any differences attributed to the PCM program.

We at TKA are committed to continued research and program development.

Appendix G
The Assessment Form

ASSESSMENT FORM

Subject Code	Type	Phase
221	_____	_____
193	_____	_____
102	_____	_____
167	_____	_____
284	_____	_____
342	_____	_____
618	_____	_____
784	_____	_____
611	_____	_____
932	_____	_____
787	_____	_____
917	_____	_____
236	_____	_____
153	_____	_____
587	_____	_____
364	_____	_____
889	_____	_____
573	_____	_____
636	_____	_____
789	_____	_____

Subject Code	Type	Phase
485	_____	_____
619	_____	_____
876	_____	_____
369	_____	_____
476	_____	_____
568	_____	_____
188	_____	_____
885	_____	_____
129	_____	_____
315	_____	_____
859	_____	_____
285	_____	_____
632	_____	_____
456	_____	_____
386	_____	_____
396	_____	_____
534	_____	_____
407	_____	_____
737	_____	_____
722	_____	_____

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