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Is Individual Temperament Centered Psychotherapy Possible: A Proposal Based on Nine Types Temperament Model

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ABSTRACT: *Although there are many psychotherapy approaches today, it can be stated that a psychotherapy approach that is based on the temperament concept, which constitutes the structural basis of individual differences, does not exist. Even though the models focusing on explaining the temperament and the personality draw attention to the importance of these concepts in psychotherapy, these models did not formulate an important psychotherapy approach that places these concepts in its center. In fact, temperament is a key concept, which forms the smallest psychological building stone of individuals, determines the psychopathologic predispositions and the duration of experiencing of the psychopathology by an individual. Thus, temperament concept can be a focus point for the therapeutic approaches. In this study, we proposed the basic approaches and methods of individual temperament centered psychotherapy from the perspective of Nine Types Temperament Model that centers temperament concept. This can be an awareness-based, non-eclectic, different, holistic and systematic psychotherapy approach which can enable the balancing of behaviors, emotions and ideas of an individual. At the same time, we tried to define a general course of actions for therapists to structure what kind of a therapeutic approach they will apply, which can be considered as a starting point to form a psychotherapy model that considers the human being in a holistic way from normal to psychopathology and focuses on causality.*

Key words: *Nine types temperament model, temperament, personality, psychotherapy*

INTRODUCTION

Psychotherapy is a process, which is interpersonal and aims to generate modifications of feelings, cognitions, attitudes and behaviors that trouble a person who seeks help from a trained professional (Strupp, 1978, p. 5).

Today, besides psychotherapy approaches based on a per se psychology theory, there are also more than 400 new psychotherapy approaches uniting fundamental psychotherapy theories and techniques (Corsini & Wedding, 2012; Palmer, 2000). The classical psychoanalysis, the oldest of systematic psychotherapy approaches focusing on understanding the human, is based on the psychoanalytical theory propounded by Freud (Freud & Breuer, 2001). Instead of Freud's approach focused on sexuality and psychopathology, Alfred Adler (1927; 1997), who considered sexuality as less important and emphasized societal elements, such as the effort of being superior, the importance of birth order and the effect of parents in personality development, was the founder of individual psychology school, which is interested in re-educating the individuals and shaping the society, instead of curing the sick individual (Corsini & Wedding, 2012). Carl Gustav Jung (1981; 1987) is the founder of therapeutic-oriented analytical psychology school which yields awareness on human condition, individual responsibility, self-consciousness and individualization. In addition, he claimed that the way an individual considers events is related with his/her perception and proposed eight different personality types based on differences of general attitude (extroverted-introverted) and basic function (thinking, feeling, perception and intuition). Neo-Freudians, who changed the classical psychoanalytical theory, developed modern analytical treatment approaches. Instead of Freud's approach focusing on id concept, Karen Horney (2013; 1942), Anna Freud (1946), Erik Erikson (Berzoff, 2008), David Rapaport (1951) and Heinz Hartmann (1958) propounded ego analysis approach focusing on the interaction of human with the surroundings. On the other hand, Rank, Ferenczi, Alexander and French proposed short-term psychodynamic therapies, aiming to rehabilitate the symptoms of the patient and focusing on the current life conditions and behaviors of the counselee (Ferenczi, 1994; Tosone, 1997; Marmor, 1979). Kohut re-interpreted the transference concept -to which Freud gave great importance- and thus proposed self-object concept and self-psychology approach (Erten, Mitrani, & Tanık, 2004, p.16). Klerman and Weissman (Weissman & Markovitz, 1994; Weissman, Markovitz, & Klerman 2008), propounded interpersonal therapy, a contemporary example of short-term psychodynamic therapies, which include strategies from both short term psychodynamic therapies and cognitive behavioral therapies.

Beck (1970) and Ellis (1969; 1980) propounded cognitive behavioral therapy (CBT) instead of psychoanalytic psychotherapy, which they criticized for not being based on experimental basis and being insufficient in clinical practice. CBT focuses on thinking and interpretation features that are unique for individuals and claims that incoherent reactions result from misperception of events and interpretation of events in a non-functional way (Corsini & Wedding, 2012, p.421). CBT is represented with two mainstreams (Köroğlu,

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2008), one is cognitive behavior therapy defending the principle that perception, interpretation and cognition of people play a role in psychological reactions (Beck, 1970), and the other is rational emotive behavior therapy, focusing on the emotions besides ideas/thoughts (Ellis, 1969; 1980). Schema therapy, based on cognitive behavioral theory to a great extent and at the same time combining the theory of attachment and object relations with techniques of gestalt and experiential therapy (Rafaeli, Berstein, & Young, 2011; Young, 1994).

Maslow (1943) and Rogers (2012), who oppose to psychoanalytic and behavioral approaches, were the pioneers of humanistic psychotherapies which emphasized that the humans should not only be considered with their psychopathological parts, but as a whole with all parts, including non-psychopathological ones. For Rogers (2012; 1961), it is important that the individual is able to accept him/herself as his/she is and he aims to create an atmosphere where the counselee is able to help him/herself in the psychotherapies. Thus Rogers developed a counselee-oriented therapy method and gave the responsibility to the counselee during the transformation period (Rogers, 2012; 1961). Another approach, which generated under the humanistic and existentialist philosophy, is existentialist psychotherapy (May, 1958; May, Angel, & Ellenberger 1958; Yalom, 1980). Existentialist psychotherapies focus on the concepts of death, freedom, isolation and meaninglessness in an individual's life (Yalom, 1980; Burger, 2006). Besides these main schools, there are many psychotherapy approaches, such as gestalt therapy, which combines various approaches and therapeutic strategies (Perls 1969), awareness therapy (Zeine, 2014), solutions oriented therapy (Molnar & Shazer, 1987), art therapy (Ulman, & Dachinger, 1996), psychodrama (Moreno, 1946), eye movement desensitization and reprocessing (EMDR) (Hyer & Brandsma, 1997) and integrative psychotherapy (Erskine & Moursund, 2011).

AN UNDERVALUED CONCEPT IN CURRENT PSYCHOTHERAPY APPROACHES: TEMPERAMENT

Although eclectic approach is preferred in many professional psychotherapy practices, it is stated that it is not satisfying (Smith, 1982). Cloninger and Cloninger (2011) claim that impersonal therapeutic approaches fail to increase the average of the physical, emotional and social well-being in a society. Many researchers agree that for psychotherapies to be more affective and personal, the concepts of temperament and personality have to take more place in psychotherapies (Burks & Rubenstein, 1979; Kline 1980; Bloch 1980; Paris, 2000, p.167).

In order to understand human behavior better, researchers developed theories and models focusing on temperament and personality concepts (Burger, 2006; Strelau, 2002). Among these theories and models, Costa & McCrae's Five Factor Personality Model (FFM) (1990), Cloninger's Psychobiological Personality Model (PPM) (Cloninger, Svrakic, & Przybeck, 1993) and Akiskal's Affective Temperament Model (ATM) (Akiskal & Mallya, 1987; Akiskal, 1998) are prominent models, widely being used in the fields of psychiatry and psychology.

Another model is the Nine Types Temperament Model (NTTM), which considers human behavior and interpersonal differences on temperament basis and proposes that the temperament causes tendency for psychopathologies, besides explaining normal behavior (Yılmaz, 2010; Yılmaz et al. 2011; 2014a; 2014b; 2015). According to NTTM, temperament is a structural core, which is innate, unchanging for lifetime, has its own unique priorities for seeking, motivation and perception and is the whole of differential traits that distinguish one individual from another (Yılmaz, 2010; Yılmaz et al., 2011; 2014a). Every temperament type is composed of both positive potentials and risky traits prone to negativity and named according to the main orientation that explains the seeking which lies at the basis of combination of these traits (Table 1). Character, on the other hand, is formed with the distinctiveness, determination and consistency of the temperament traits (Yılmaz et al., 2015). Personality is the whole of behavioral, emotional and cognitive traits that are formed according to the interaction of innate/internal factors (intelligence, gender, genetic structure, age, biological traits, etc.), on which we cannot have an impact, and external/environmental factors (family, education, social environment, life experiences, culture, belief, etc.), on which we can have a partial impact (Yılmaz et al., 2014a; 2014b). In other words, temperament bears the structural program of the personality and personality is a dynamic structure that develops over the structural and static condition of the temperament (Yılmaz et al., 2014b; 2015).

Neither the temperament and personality models focus on psychotherapy, nor the psychotherapy models focus on the temperament concept, which also shapes the normal emotions, ideas and behaviors (Strelau, 2002; Yılmaz et al., 2014b) thus, a psychotherapy approach that can consider both normal and abnormal psychology in a holistic and comprehensive manner is not developed yet. We hypothesized that it is possible to have an awareness-based, non-eclectic, different and holistic model, which enables the balancing of emotions, ideas and behaviors of an individual, as aimed by cognitive model therapy, schema therapy and awareness therapy. At the same time, it can be proposed that a psychotherapy approach centering the innate temperament can make way for a consistent and comprehensive psychobiological model which is in accordance with the view that personality is the most basic factor in the formation of symptoms and diagnoses, as proposed by A. Meyer decades ago (Kaplan & Sadock, 2007).

The aim of this study is to propose a new and holistic individual temperament centered psychotherapy approach from the perspective of NTTM, which explains an individual's emotional, cognitive and behavioral traits on the basis of temperament and propounds that the temperament forms the basis for both normal and psychopathological predisposition. At the same time, this study aims to define a course of action for therapists to structure the therapeutic sessions starting from the first session according to individual temperament centered psychotherapy approach.

THE RELATION OF TEMPERAMENT AND PSYCHOPATHOLOGY

In the literature, there are numerous studies which prove that temperament and personality structures are affective on the etiology, clinical manifestation and discourse of psychopathologies (Clark, 2005; Clayton et al., 1994; D'Ambrosio et al., 2010; Harnic et al., 2013; Krueger et al., 1996; Muris & Ollendick, 2005; Nigg et al., 2002). Temperament not only can play a predisposing role in the generation of psychopathologies, but also interact with its surroundings and cause a different clinical manifestation for the same disease (Hranov et al., 2013; Rettew et al., 2006). Rovai et al (2013), claim that temperament plays a role in both normal and psychopathological realms. There are also studies in the literature that displaying of temperament traits less or more can cause psychopathology (Rovai et al, 2013; Cloninger et al., 1998; Thomas, 1968). Nine Types Temperament Model considers temperament as a source for displaying both normal and psychopathological personality traits for individuals (Yılmaz et al., 2014b). In addition, this model claims that temperament can be predisposing for some symptoms and diagnosis categories (Yılmaz et al., 2011). This view can be expanded as what lies at the very root of psychopathologies is whether the individual's own temperament type traits are displayed less or more on personality manifestations. For example, if an individual with Nine Types Temperament (NTT) 1 type, who has traits such as being perfectionist, meticulous, neat, detailed and strict, displays these traits excessively in personality manifestation, it can manifest as obsessive compulsive personality disorder.

Table 1.
Traits of Nine Types Temperament Model Types

Temperament Types	Positive Potentials	Risky Features
NTT1-Perfection Seeking	Serious, Mature, Idealist, Fair, Righteous, Perfectionist, Disciplined, Persistent, Diligent, Meticulous, Neat, Principled, Controlled, Coldblooded, Rational, Temperate, Acting With Plan, Formalist, Consistent, Responsible, Defining, Planning, Classifying, Comparing, Categorizing, Systematic, Reformist	Moralist, Critical, Judging, Too Detailed, Easily Getting Angry and Tense, Strict.
NTT2-Seeking to Feel Emotions	Full of Love, Relation Oriented, Very Emotional, Revealing Emotions, Warm-Hearted, Extroverted, Sincere, Talkative, Sympathetic, Compassionate, Strong Communication Skills, Amiable, Pitying, Helper, Altruistic, Giving	Quickly Affected, Touchy, Persistent, Tenacious, Reproachful, Likes to Get Attention, Jealous, Manipulative
NTT3-Admirable Self Image Seeking	Success and Career-Oriented, Competitive, Goal-Oriented, Not Taking Negative Feelings as an Obstacle, Motivator, Popular, Diplomatic, Practical, Adaptive, Zealous, Hardworking, Productive	Ambitious, Status Seeking, Self-Seeker, Cunning
NTT4-Seeking Meaning of Emotions	Individualistic, Unique, Extraordinary, Empathetic, Intense Emotional, Designer, Artistic, Has Aesthetic Perspective, Identity Seeking, Sensitive, Natural, Sincere, Friendly, Compassionate, Romantic	Rebellious, Marginal, Melodramatic, Easily Hurt/ Vulnerable, Melancholic, Passionate, Envying
NTT5-Seeking the Meaning of Knowledge	Introverted, Quiet, Observer, Analytical Thinking, Deeply Curious, Rationalist, Objective, Investigator, Abstracting, Conceptualizing, Specialist, Archivist	Sceptic, Asocial, Cold, Distant, Distant From Emotions, Stingy
NTT6-Intellectual Serenity Seeking	Safety and Security Oriented, Team Player, Cares About Loyalty, Spontaneous Curiosity, Collecting Data, Not Showing his True Colors, not Distinguished, Cautious, Thrifty, Meticulous, Neat, Covering all Bases, Secretive	Anxious, Worried, Needs Authority, Paranoid touchiness, Pessimistic, Insecure / Mistrustful, Cheeseparing, Opponent, Ambivalent, Indecisive, Unsure, Suspicious, Obsessive, Controller
NTT7-Seeking Joy of Discovery	Prone to Novelty, Curious to Discover, Active, Enterprising, Extroverted, Quickly Establishing Relations, Talkative, Experiencing, Visionary, Innovative, Creative, Imaginative, Cheerful, Witty, Optimistic, Practical, Quick associations, Seeking Excitement	Avoiding Boredom, Untidy, Extravagant, Trouble-free, Exaggerating, Impatient, Easily Bored, Unplanned, Impulsive, Scattered Attention, Whimsical, Flight of Ideas
NTT8-Absolute Power Seeking	Leader, Self-Confident, Brave, Generous, Patronizing/Protecting, Contestatory, Challenging, Outspoken, Entrepreneur, Quick to Go Into Action, Clear, Enduring	Dominating, Oppressive, Authoritarian, Grandiose, Tough, Intervening, Intolerant, Furious, Combative, Prone to Violence
NTT9-Sensory Motor Comfort Seeking	Calm, Harmonious, Peaceable, Peacekeeper, Mild, Peaceful, Not Judging, Integrating, Avoiding Conflicts, Soft, Pliant, Patient, Likes Routing, Letting Things Flow	Sluggish, Passive Resistance, Having Trouble Saying No, Not Getting Involved, Suppressing Anger, Postponing, Shy

NTT: Nine Types Temperament

Wachtel (1994) points out that both internal and external state are effective in the formation of psychopathologies. However, considering that the way an individual perceives and interprets external events is also related with the temperament (Goldsmith et al., 1987), it can be propounded that the psychopathologies are generated as a result of the interaction of internal and external factors with the temperament (Yılmaz et al., 2014b). For example, let us consider one child with temperament type NTT8, who is enduring, challenging, aggressive and prone to violence and one child with temperament type NTT9, who is withdrawn, shy, avoids conflicts and suppresses his/her anger. Under the condition that these two children are subjected to violence, it can be predicted that they will perceive this condition differently and react differently (Yılmaz, 2010). It can even be stated that this condition can increase the occurrence risk of antisocial personality disorder in the child with NTT8 temperament and avoidant personality disorder or social phobia in the child with NTT9 temperament (Yılmaz et al., 2011). Both normal and abnormal psychopathological traits originate from the temperament structure (Yılmaz et al., 2011; 2014b; Rovai et al., 2013). In addition, symptom and diagnoses are closely related with the personality, which develops from the temperament (Clark, 2005; Svrakic et al., 1993; Yılmaz et al., 2014b). Therefore, NTTM argues that the temperament, which is the basic structural core of the personality and the source of both normal and psychopathological traits of the individual, needs to be centralized in psychotherapies (Yılmaz et al., 2014b; 2015).

THE CONCEPTUAL APPROACHES OF CURRENT TEMPERAMENT AND PERSONALITY MODELS AND NTTM AND THEIR EFFECT ON CLINICAL PRACTICE

Although there are psychoanalytic, humanistic, social learning and cognitive theories in references that study personality theories, actually these theories focus on explaining the personality organization and its development, rather than determine the traits that make up the personality (Burger, 2006; Corr & Matthews, 2009; Maltby, Day, & Macaskill, 2010). On the other hand, approaches that focus on conceptual study of the personality divide the temperament and personality according to dimensions or categories, thus providing a study applicable to scientific investigation (Cloninger et al., 1993; Cattell, 1943; Allport & Allport, 1921; Costa & McCrae, 1995). Among the current theories that adopt this approach and are being widely used in psychiatry and psychology, Big Five Model (BFM), Affective Temperament Model (ATM) and Psychobiological Personality Model (PPM), have methodological similarities with NTTM in studying the temperament and the personality. In this section, we will consider the basic conceptual characteristics of NTTM and these models according to their therapeutic approaches and their impact on practice.

Costa and McCrae (1994a; 1994b), who developed BFM, argue that personality traits are stable throughout the adulthood. However, many studies prove that personality traits are not stable during the adulthood (Côté & Moskowitz, 1998; Mroczek & Spiro 2003; Allemand, Zimprich, & Hertzog, 2007; Rantanen et al., 2007; Roberts, Walton, & Viechtbauer, 2006; Donnellan & Lucas, 2008). Under the light of all these studies, it can be stated that BFM is limited to determine the traits of an individual that are unchanging throughout a lifetime. The reason for this can be explained as Costa and McCrae do not consider temperament and personality concepts from the perspective of the unchanging temperament and the dynamism of personality that develops on the basis of temperament (Yılmaz et al., 2014b; 2015). Another limitation of BFM is that although it considers personal differences according to common dimensions, it cannot explain the differences between individuals who have similar scores on the same dimension (Burger, 2006; McCrae & John, 1992). On the other hand, NTTM considers the temperament as an innate structural core that is unchanging throughout a lifetime and

that forms the personality. Contrary to the approach of BFM, NTTM propounds that the traits of individuals which are stable throughout a lifetime correspond to the temperament traits, not personality traits (Yılmaz et al., 2014a; 2014b). In addition, since temperament traits of individuals will always interact with internal and external factors in a degree/way unique to individuals themselves, NTTM can also emphasize the uniqueness of the individual (Yılmaz, 2010; Yılmaz et al., 2014b).

PPM is another model focusing on the determination of personality traits (Cloninger et al., 1993). According to this model, personality is explained with the formula: temperament + character = personality (Maltby et al., 2010). NTTM opposes the approach of Cloninger, which considers temperament and character as two separate components that make up the personality, propounding that character and personality are developed from the temperament core and there is a linear relation between temperament, character and personality (Yılmaz et al., 2014b).

On the other hand, according to Akiskal temperament is inherited and changes little throughout life time; it is the structural core of emotional, motivational and coherence-oriented behavior automatisations of personality (Akiskal, 1998; Akiskal et al., 1989). Akiskal's studies focus more on the affective part of the temperament (Akiskal et al., 2000; Akiskal, 1994). NTTM, contrary to Akiskal's affective temperament categories, defines temperament as a whole with its emotional, cognitive and behavioral parts (Yılmaz et al., 2014b). In addition, Akiskal mostly evaluates individuals according to their psychopathological moods, thus not emphasizing the non-psychopathological mood manifestations of temperament structure (Akiskal, 1998; Akiskal et al., 1989; Akiskal & Akiskal, 2005). However, contrary to Akiskal's approach focusing on psychopathology, Rovai et al. (2013) claim that the temperament plays a role in both normal and psychopathological realms. On the other hand, NTTM explains the relation of the temperament with normal and psychopathological realm as thus: Temperament constitutes of a group of simple traits. However, every temperament structure has traits which are prone to positivity and negativity (Yılmaz, 2010). Thus, while the temperament is the basis of the normal structure, it can also play a predisposing/potential role in the psychopathology development (Yılmaz et al., 2014b). Therefore, the temperament transfers normal and psychopathological predispositions to the personality, which develops from the temperament itself (Yılmaz et al., 2011). The occurrence of these predispositions is related with the dynamic personality manifestations (Yılmaz et al., 2014b; 2015). For example, temperament traits of an individual with NTT7 temperament type, such as seeking for novelty and excitement, having quick associations and flight of ideas, being curious and having difficulty in keeping attention can be a source to an innovative, active and productive manifestation (normal) or attention deficit and hyperactivity disorder manifestation (abnormal) in personality.

According to McCrae and John, the criterion that determines the academic importance of theories claiming to explain human behavior is the new proposals and approaches these theories introduce to the psychopharmacological and psychotherapeutic fields (McCrae and John, 1992). However, the discriminating trait approach that is the basis of BFM usually focuses on defining the personality and determining to what extent an individual has a particular trait, rather than explaining the underlying mechanisms of behaviors (Burger 2006; Wiggins, 1997). In addition, the researchers who adopt this approach focus more on the academic field than clinical practice, therefore there is not any important psychotherapy schools resulting from the discriminating trait approach (Burger, 2006). Although there are studies in the literature showing that PPM affects psychopharmacological choices (Marchesi et al., 2006; Lyoo et al., 2003; Kaneda et al., 2011; Hellerstein et al., 2000; Sato et al., 1999), there is not any algorithmic pharmacotherapeutic treatment scheme for a psychiatric symptom or diagnosis as a result of all these studies. Besides pharmacotherapeutic studies, PPM is subject to many psychotherapeutic studies (Fassino et al., 2003; Anderson et al., 2002; Joyce et al., 2007). According to the data of these studies, it is noticed that instead of providing a new approach, PPM is used for measuring the efficiency of the present psychotherapeutic methods or determining the patient profile which these methods can be affective for or providing only theoretical information for psychotherapies (Cloninger & Cloninger, 2011; Cloninger & Svrakic, 1997; Svrakic et al., 2002). On the other hand, Akiskal focuses mostly on psychiatric diagnosis and treatment of mood disorders and his model is limited to affect the approaches related with other disorders (Akiskal, 1983; Akiskal & Van Valkenburg, 1994; Akiskal et al., 2006). In addition, although Akiskal presented with MR images that the differences between temperament categories he proposed are related with the differences among the subcortical structures of the brain (Serafini et al., 2011), he did not yet propose a particular model based on the view that determination of temperament categories can influence the pharmacotherapeutic and psychotherapeutic approach. NTTM can be considered as a convenient model both for academic researches and clinical practice due to its holistic approach which explains a) the relation between an individual's static temperament traits that are unchanging through lifetime and dynamic personality traits, which can change through the course of life, b) the basic seek of life, motivation and underlying reasons of individuals' behaviors on the basis of temperament, c) the common traits between individuals on temperament basis, and the differences and the uniqueness of individuals on personality basis (Yılmaz, 2010, Yılmaz et al., 2014a; 2014b). Therefore, it can be claimed that NTTM is a unique model, suitable for proposing a psychotherapy model according to its perspective and determines temperament types and traits for each temperament type categorically. In addition, possible relations, which can be found between the temperament types and neurobiological parameters with organic based imaging studies conducted with NTTM, can have a profound impact on diagnosis and treatment (pharmacotherapeutic and psychotherapeutic) approaches (Yılmaz et al., 2011; 2014b).

TEMPERAMENT AND PSYCHOTHERAPY

According to Roger's counselee-centered therapy approach, the individuals can only be understood from the perspective of their own perception and emotions (Rogers, 2012; 1962; Davison & Neale, 2007). The way they experience events is important, rather than the events themselves. This is because every individual's phenomenological world is the most important determinant of behavior and it makes an individual unique (Davison and Neale, 2007). Actually the temperament is the most fundamental structure that determines the perception, motivation and seeking of individuals and thus shape their phenomenological world (Yılmaz, 2010). We believe that understanding how an individual perceives events and how his/she interprets them can only be possible through knowing his/her temperament type. We also claim that this approach can be an important guide to clinicians for understanding resistant counselees. According to Young et al, problems of some counselees are at the center of their sense of identity. For such counselees, giving up their problems means letting go of a part of their characteristic features, therefore they can be unwilling for treatment (Young, Kolosko, & Weishaar, 2008, p. 21). Thus, according to our view, first understanding the temperament type that is the foundation for sense of identity and characteristic traits is important (Yılmaz, 2010; Yılmaz et al., 2014a; 2014b). This way, a temperament oriented approach, which is based on recognizing, understanding and accepting the innate and unchanging traits of counselees, can be the most efficient way to reach the inner world of these counselees.

Cognitive behavioral therapy (CBT) methods are widely used today and their efficiency was proved in many psychiatric diseases (Butler, Chapman, Forman, & Beck, 2006). Although CBT considers

human behavior and psychopathologies via a phenomenological approach, these methods do not consider their causality. At the same time, CBT focuses more on Axis I psychopathologies; its operation is based on symptoms and can be insufficient for the treatment of counselees with chronic problems on temperament and character traits (Young, Klosko, & Weishaar, 2003). Schema therapy, which originates from CBT and cares more about causality, focuses on schemas developed by individuals since their childhood, which have an important impact on the development of selfhood (Hawke and Provencher, 2011). It is claimed that schemas originate from the interaction of the individual's temperament with the environmental factors (Rafaeli et al., 2013; Young et al., 2003). However, how this interaction occurs and how these schemas are formed is not defined (Halvorsen et al., 2009). On the other hand, NTTM focuses on the temperament differences, -which may, in the future, determine how these schemas are formed- (Yılmaz et al., 2011; 2014b; 2015). For example, let us consider altruism schema, which consists of the individual's voluntary over-focusing on fulfilling others' needs at the expense of his/her own happiness. According to the schema therapy, this originates from the individual's over sensitivity to others' pains and sometimes can cause the individual to feel that his/her own needs are not met (Rafaeli et al., 2013). Considering from the NTTM perspective, some temperament types (NTT2, NTT6 and NTT9) are more prone to develop this schema and it can be stated that every temperament type that develops this schema has different motivations. For example, an individual with NTT2 temperament type, who is prone to be giving and altruistic for the sake of getting love and attention; another individual with NTT6 temperament type, who wants to be approved by those whom his/she considers as a safety figure and to sustain the trust and loyalty relation with them; and an individual with NTT9 temperament type, who delays his/her personal needs not to disrupt the harmony with the environment his/she integrated into and may choose to be compatible with others (Yılmaz, 2010), have different motivations and priorities for predisposing to develop this schema. Therefore, it is possible to develop solution approaches and proposal strategies unique to individuals' motivations with different temperament types who form the same schemas.

Actually, the idea of adapting psychotherapy techniques according to temperament structures in psychotherapies is not new (Burks & Rubenstein, 1979; Kline 1980; Bloch 1980; Paris, 2000). However, we believe that an individual-temperament centered psychotherapy approach could be proposed from the systematic perspective of NTTM, in which the temperament -which bears the codes of all the normal and psychopathological behavior, emotion and cognition traits- is placed in the center of psychotherapy, instead of adapting temperament types to therapy techniques. In the following section, there are more detailed and systematic proposals regarding our psychotherapy approach.

A NEW PSYCHOTHERAPY APPROACH PROPOSAL FROM THE PERSPECTIVE OF NINE TYPES TEMPERAMENT MODEL

Objectiveness in Therapy

Theories and psychotherapeutic systems propounded by Freud, Jung and Adler are seen as an extension of their personalities (Corsini & Wedding, 2012, p. 39; Dumont & Corsini, 2000). In addition, it is known that personality traits of therapists affect the therapy duration and its impact (Heinonen, Lindfors, Laaksonen, & Knekt, 2012). Using this data, it is possible to state that the theoretical approach the therapist chooses and the way his/sheestablishes relationships is closely associated with the temperament traits that make up the therapist's personality. Although many psychotherapy approaches indicate that the therapist needs to be objective in a healthy therapeutic relationship (Hersen & Seledge, 2002), Muran (2007) states that the individuals -due to human nature- cannot have an objective, neutral perspective independent from their own personal perception. In cognitive behavioral therapies, although a complete objectivity in therapist-counselee relation is not mentioned, it is claimed that therapist should be positioned closer to objectivity (Gilbert & Leahy, 2007, p. 177). We also believe that an ideal and genuine understanding in therapy can only be possible with objectivity, however, like every individual, the way a therapist perceives and interprets the world develops on the basis of his/her own temperament type, therefore we argue that his/she cannot be completely objective. Therefore, according to us, only a therapist who is aware of the temperament predispositions that shape his/her own perspective and evaluations can establish a healthy therapy relationship with his/her counselees based on a real understanding.

Therapeutic Relation in the Context of Temperament and Personality

All psychotherapy approaches pay attention to how the relation between the therapists and counselees should be. According to psychoanalytic theories, the transference and counter transference between the counselee and the therapist is centralized in the therapeutic relation and forms the therapeutic/rehabilitative effect of the therapy (Racker, 1957). On the other hand, the therapy techniques are at the center of the therapy in behavioral approach and the therapeutic relation is not focused on (Türkçapar, 2008). Perls, the pioneer of gestalt approach, argues that the relation is important in therapy, not the techniques (Perls, 1969; Korkut, 1992). Cognitive behavioral therapy draws attention to the importance of both the relation and the techniques and resembles the therapeutic relation between the therapist and the counselee to the relations of master-apprentice and teacher-student (Türkçapar, 2008; Beck, 1979). We believe that both the techniques and the therapeutic relation is important in psychotherapies, however, according to our opinion, therapeutic relation has a more prior importance than the techniques. As a matter of fact, we claim that psychotherapeutic techniques should be used as a part of the relation, which will be established according to the temperament type of the counselee. Therefore, we draw attention to the importance of mastering the temperament types for a therapist, which will shape the relation between the therapist and the counselee starting from the moment the therapist meets the counselee in the therapy room.

From the moment that a therapist establishes a relation with a counselee, his/she deals with a) dynamic personality pattern, b) character, originating from the temperament and resistant to change, and c) static temperament traits. Therefore, the therapist has to evaluate these three linear-related structures. For example, let us consider a counselee of NTT4 temperament type with complaints, such as feeling of void, unhappiness, meaninglessness and aimlessness. This individual will transfer his/her complaints over the personality pattern shaped by the internal and external impacts from his/her birth until today. In fact, the temperament type of the counselee lies at the root of this personality pattern (Yılmaz et al., 2014b). By knowing the counselee's temperament type, the therapist can also understand that essentially these complaints originate from the seeking for meaning of emotions, thus in order to fulfill this, the counselee wishes to have an extraordinary and unique identity and is troubled by feeling ordinary (Yılmaz, 2010). With this perspective, the therapist has the advantage of considering and understanding the counselee as a whole from the normal to psychopathological traits based upon the temperament, quickly establishing a therapeutic relation in accordance with the counselee's temperament and determine therapeutic aims and strategies unique to the counselee.

At the same time, knowing temperament types would help the therapist to discern the differences between the underlying reasons for

the complaints of counselees with similar symptoms. For example, let us consider another counselee, an NTT1 type, again with similar complaints like feeling of void, unhappiness, meaninglessness and aimlessness. Although this counselee's complaints can be the same with those of NTT4 type counselee's, the complaints of this individual originate from seeking perfection. Individuals seeking perfection display these symptoms as a result of the disappointment they face when things do not work out without mistakes or in the order they want (Yılmaz, 2010; Yılmaz et al., 2014b). Therefore, a therapist who masters temperament types can understand that even though the counselees of different temperament types have similar or same complaints, this originates from their different motivational seeking. Also, the therapist is able to know that the same motivational seeking lies at the root of complaints of counselees with same temperament type but different personality patterns. For example, let us consider two counselees of NTT6 type with complaints like anxiety, indecisiveness and pessimism. Essentially, the complaints of both counselees originate from seeking the intellectual serenity and in such situations, they need a wise, consistent and decisive authority figure who can give them confidence (Yılmaz et al., 2014a; 2014b). However, one of the counselees might openly show his/her seek for authority with the tendency to be cooperative and coherent with the therapist, while the other one can show it in an ambivalent way, disguised with intricate and narcissistic attitudes, due to the influence of environmental factors. Therefore, the therapist can understand that even though the personality manifestations of the counselees with the same temperament type are different, their complaints originate from the same motivational seek. This way, even in the first session, the therapist can recognize the counselee on the basis of his/her static temperament traits which are innate and unchanging throughout the life time (Yılmaz et al., 2014b). The temperament type of the counselee is the subjective expressions of his/her fundamental motivational seek, while his/her personality manifestation is the subjective expression of the way his/she experiences the symptoms. Therefore, a therapist with NTTM approach can see the common traits of the counselee with others in the same temperament category and his/her personality pattern which makes him/her unique, at the same time. This can make a real individual-temperament centered therapy possible.

Therapist-Counselee Relation in the context of Awareness

Awareness concept, originating from spiritual traditions of the Far East, has become an important element of psychotherapy approaches in the West for nearly 30 years (Tart & Deikman, 1991; Çatak & Ögel, 2010). In a general expression, awareness can be defined as the ability to pay attention in order to focus on the present moment (Crane, 2009, Ögel, 2012). Some researchers focus on the awareness of ideas and relate awareness with higher cognitive processes (Çatak & Ögel, 2010; Toneatto, 2002; Wells, 2002; Bishop et al., 2004; Garland, 2007; Corcoran & Segal, 2008), while others focus on the effect of awareness on the emotional regulation (Lynch & Bronner, 2006; Hayes & Feldman, 2004; Coffey & Hartman, 2008; Roemer et al., 2008; Mitmansgruber et al., 2009). According to our view, awareness for an individual is the objective knowing of all physical, emotional and cognitive attitudes and behaviors in the present-moment.

Awareness therapists explain unawareness concept -the opposite of awareness concept- as the automatic pilot, which is a mind state where the individual is unaware of his/her sensual perceptions or does not have any conscious target (Crane, 2009, p. 21; Williams et al., 2006, p. 108). Parallel to the automatic pilot concept, we propose that all individuals, who did not perform any special awareness exercises, feel, think and act automatically according to their temperament traits. In other words, if the individual is not in a state of awareness, the program that processes the automatic pilot is the individual's temperament structure. According to their temperament traits, individuals react the same way to the similar internal or external stimuli. For example, individuals with NTT6 temperament type have a safety and security oriented, precautious, controller, indecisive and ambivalent frame of mind. When facing a situation where they have to make an important decision, automatically and simultaneously positive and negative ideas will come to their mind, then their minds will be concerned more with the negative ideas and they will need to consult a wise authority figure whom they trust, in order to fulfill intellectual serenity, the fundamental seek of their temperament type (Yılmaz, 2010).

An individual can reach the awareness level by first noticing the way his/she experiences his/her own temperament and personality traits in his/her life, then working with a guide, who has a higher level of awareness than him/her (psychiatrist, psychologist, psychotherapist, psychological counselor), on his/her automatic perception with an intense attention and effort. This requires the establishment of a healthy therapeutic relation based on a genuine understanding and acceptance between the therapist and the counselee. The researchers give particular importance to the following features of therapists in an efficient therapy process: being concerned, empathetic, non-rigid, reflective, and able to manage complicated human relations, thinking creatively and establishing real human relations (Lafferty, Beutler, & Crago 1989; Miller, 1993; Strupp, 1995). According to us, upon the condition that the therapist has awareness concerned with him/her, then his/she can display these traits. We claim that in order to establish and sustain a relation based on awareness, first the individuals need to recognize their temperament types, which is the automatic programmer of their emotion, thinking and behavior traits.

The Focus and a Proposal for Application Method of Individual Temperament Centered Therapy

According to our view, the fundamental aim of the therapy should be reaching a functional balance from behavioral, emotional and cognitive aspects at the end of a therapeutic process, during which the counselee will display the risky traits in his/her temperament, which are prone to negativity, at the lowest level and display the positive potentials in an average level. To achieve this, all the steps that an individual temperament centered psychotherapy oriented therapist has to follow from the initial session are presented in Table 2. (The methodical approach summarized in this table is not suitable for psychotic or mentally retarded patients)

CONCLUSION

Although there are many psychotherapy approaches today, it can be stated that a causality-oriented, comprehensive, systematic human model, which considers the human being in a holistic way from normal to psychopathology and regards the individual differences does not exist, nor does such a psychotherapy approach. In fact, temperament and personality concepts, which form the smallest psychological building stone of individuals and determine the psychopathological predispositions, as well as the individual experience process of psychopathology, are key concepts that can be the focus of therapeutic approaches. However, current temperament and personality models, which stress the importance of temperament concept, are not suitable enough to create a psychotherapeutic model, considering the way they handle and define temperament, character and personality concepts.

With this study, we proposed the fundamental approach and methods of individual temperament centered psychotherapy, an awareness-oriented, non-eclectic, different, holistic and systematic psychotherapy approach which centers temperament concept through Nine Types Temperament Model perspective and establishes behavior, emotion and thinking balance in an individual. At the same time, we tried to define a very general course of actions for therapists to structure the therapeutic session from the beginning. The limitation

Table 2.
A Guide for Therapists According to Individual Temperament Centered Approach

1) General Recognition ~ 5-10 min	a) First of all, personal identity information of the counselee is recorded. Then, the counselee is questioned about the traits which shape his/her personality, such as age, education, professional career, economic status, marriage, birth place and place of living.	
	b) The counselee is questioned about whether he/she faced a prior psychiatric disease treatment or has a psychotherapy history.	
2) Diagnostic Evaluation ~ 10-15 min	a) Shortly–without going into detail- reason for admission and complaints are questioned.	
	b) Events which can cause symptoms and complaints are investigated and the counselee's individual and environmental perception is acquired from life events. In view of all these data, first diagnostic evaluation is extended in terms of diagnostic categories.	
3) Determination of Temperament Type ~ 10-15 min	After the application of 36-item short form derived by us from 91 item Nine Types Temperament Scale (NTTS) (Yılmaz et al, 2014a), as a self-report scale, the temperament type is clearly determined by the therapist by applying a comparative adjective list among the three top scoring types (yes:2, sometimes:1, no:0).	
4) Treatment Strategy, Informing and Therapeutic Decision ~15-20 min	a) Symptomatic recovery: In order for the counselee to be included in the therapeutic relation and get ready for etiological recovery without the perception that he/she is under the pressure of symptoms, pharmacotherapeutic agent treatment is initiated, if necessary. (If the therapist is not a medical doctor, then he/she will direct the counselee to a medical doctor for psychopharmacologic treatment.) Then, for etiological recovery, considering the intellectual capacity, therapeutic demand and orientation of the counselee, whether the counselee will attend psychotherapy or not.	
	b) Etiological recovery	1) Balancing of Intellectual (Physical, Emotional and Cognitive) Functions: At this phase, the aim of the therapist is to conduct a therapeutic work with the aim of disappearing the symptoms and diagnoses which result from the individual's own temperament automatism and which are triggered by the environmental factors. The individual is introduced to his/her own automatism related to his/her temperament and is encouraged to recognize that his/her complaints are indeed associated with his/her automatic affection, cognitive orientation and behaviors (by making connections between the reasons of the counselee's admission and life events with the temperament automatism). At this phase, instead of being active, generally the therapist is in a reflective position for the counselee's automatism. After the complaints of counselee disappear and he/she reaches a physical, emotional and cognitive balance in daily life, then the therapist and the counselee decide on whether they will progress to the second phase of the psychotherapeutic process or not. Since the counselee recognizes his/her own temperament automatism now, the therapist explains him/her that in the next stage in order to be able to act outside the automatic tendencies, the therapist will be much more active and guiding, and from time to time the therapist can give assignments which will force the counselee's nature. A verbal contract is made between the counselee, who wants to continue the awareness phase voluntarily with the therapist, so that the counselee will abide the therapist's orientation and interventions in an a priori acceptance and trust relation.
		2) Raising Awareness: At this phase, the aim of the therapist is to conduct a therapeutic work in order to raise the counselee's awareness and act out of his/her own automatism. During this process, the daily subjects, events and relations brought up by the counselee in the sessions are used by the counselee to interpret them according to his/her temperament automatism's perspective and thus the counselee confronts him/herself. This way, the counselee will try to realize how he/she experiences his/her automatism in daily life. For example, for a counselee with NTT2 temperament type, who has complaints about being furious in interpersonal relations, first the counselee's attention is drawn to the fact that the fury originates due to the need for getting love and attention, which results from the counselee's own temperament automatism, instead of the experienced events and processes. Then the counselee is confronted with the fact that although he/she is giving and altruistic in his/her relations, a peevishness, reproach and fury cycle is generated when he/she cannot find the attention and love he/she expected. Following this, the counselee is given relation assignments contrary to being dependent to relations in the name of love and attention demand, as well as inability to reject. The assignments and exercises, which enables the counselee to realize that his/her behaviors and attitudes originate from the automatic emotional and cognitive needs based on the temperament, are completely specific for the counselee. This is the individual temperament centered aspect of the therapy. Awareness attained at the end of this stage of the therapy will enable the counselee to acquire a supra-temperamental perception and understanding without being stuck to the perspective of his/her own automatism. Total duration of the therapy varies according to the counselee's temperament traits, intellectual capacity, psychological investment for the therapy and life events.

of this study is that, since it is a general introduction to individual temperament centered psychotherapy approach, it does not mention how a session room should be in individual temperament centered psychotherapies, what are the approach and attitude strategies special for temperament types, what can be the assignments and awareness exercises according to different temperament types and how the awareness level of the therapist reflects in the sessions. In addition, the necessity to conduct more clinical studies with NTTM, which forms the theoretical substructure of the individual temperament centered psychotherapy approach, can be accepted as another limitation. According to our view, if the individual temperament centered therapy approach and methodology can be supported with future scientific studies, it can be a candidate to become a holistic, systematic and effective psychotherapy approach, oriented for both normal and psychopathological individuals.

REFERENCES

Adler, A. (1997). *Understanding life: An introduction to the psychology of Alfred Adler*. Brett C (ed.). Oxford: Oneworld.

Akiskal, H.S, & Van Valkenburg, C. (1994). *Mood disorders.* In Diagnostic interviewing (pp. 79-107). USA: Springer.

Akiskal, H.S. (1983). Dysthymic disorder: psychopathology of proposed chronic depressive subtypes. *The American Journal of Psychiatry*, *140*, 11-20.

Akiskal, H.S. (1994). The temperamental borders of affective disorders. *Acta Psychiatrica Scandinavica*, 89, 32-37.

Akiskal, H.S. (1998). Toward a definition of generalized anxiety disorder as an anxious temperament type. *Acta Psychiatrica Scandinavica*, *98*, 66-73.

Akiskal, H.S., & Mallya, G. (1987). Criteria for the soft bipolarspectrum: treatment implications. *Psychopharmacology Bulletin, 23*, 68-73.

Akiskal, H.S., Bourgeois, M.L., Angst, J., Post, R., Möller, H.J. & Hirschfeld, R. (2000). Re-evaluating the prevalence of and diagnostic composition within the broad clinical spectrum of bipolar disorders. *Journal of Affective Disorders, 59*, 5-30.

Akiskal, H.S., Cassano, G.B., Musetti, L., Perugi, G., Tundo, A. & Mignani, V. (1989). Psychopathology, temperament, and past course in primary major depressions. 1. Review of evidence for a bipolar spectrum. *Psychopathology, 22*, 268-277.

Akiskal, H.S., Kilzieh, N., Maser, J.D., Clayton, P.J., Schettler, P.J., Traci Shea, M., et al. (2006). The distinct temperament profiles of bipolar I, bipolar II and unipolar patients. *Journal of Affective Disorders*, *92*, 19-33.

Akiskal, K.K, & Akiskal, H.S. (2005). The theoretical underpinnings of affective temperaments: implications for evolutionary foundations of bipolar disorder and human nature. *Journal of Affective Disorders*, *85*, 231-239.

Allemand, M., Zimprich, D., & Hertzog, C. (2007). Cross-Sectional Age Differences and Longitudinal Age Changes of Personality in Middle Adulthood and Old Age. *Journal of Personality, 75*, 323-358.

Allport, F.H., & Allport, G.W. (1921). Personality Traits: Their Classification and Measurement. *The Journal of Abnormal Psychology and Social Psychology, 16*, 6.

Anderson, C.B., Joyce, P.R., Carter, F.A., McIntosh, V.V. & Bulik, C.M. (2002). The effect of cognitive-behavioral therapy for bulimia nervosa on temperament and character as measured by the temperament and character inventory. *Comprehensive psychiatry, 43*, 182-188.

Beck, A.T. (1970). Cognitive therapy: Nature and relation to behavior therapy. *Behavior therapy*, *1*, 184-200.

Beck, A.T. (1979). *Cognitive Therapy and The Emotional Disorders*. UK: Penguin.

Berzoff, J. (2008). Psychosocial ego development: The theory of Erik Erikson. Berzoff, J., Melano, L., & Hertz, F.P. (eds.) *Inside out and outside in: Psychodynamic clinical theory and psychopathology in contemporary multicultural contexts*, 99-120.

Bishop, S.R., Lau, M., Shapiro, S., Carlson, L., Anderson, N. D., Carmody, J., et al. (2004). Mindfulness: a proposed operational definition. *Clinical Psychology: Science and Practice, 11*, 230-241.

Bloch, S., (1980). Temperament Styles in Adult Interaction: Applications in Psychotherapy. *American Journal of Psychiatry, 137*, 1146-1146.

Burger, M.J. (2006). *Personality*. Istanbul: Kaknüs Press (Turkish).

Burks, J., & Rubenstein, M. (1979). *Temperament styles in adult interaction: Applications in psychotherapy*. New York: Brunner/ Mazel.

Butler, A.C., Chapman, J.E., Forman, E.M., & Beck, A.T. (2006). The empirical status of cognitive-behavioral therapy: a review of meta-analyses. *Clinical Psychology Review*, *26*, 17-31.

Çatak, P.D., & Ögel, K. (2010). Mindfulness Based Therapies and Therapeutic Processes. *Clinical Psychiatry, 13*, 85-91. (in Turkish)

Cattell, R.B. (1943). The description of personality: Basic traits resolved into clusters. *The Journal of Abnormal and Social Psychology*, *38*, 476.

Clark, L.A. (2005). Temperament as a unifying basis for personality and psychopathology. *Journal of Abnormal Psychology, 114*, 505.

Clayton, P.J., Ernst, C. & Angst, J. (1994). Premorbid personality traits of men who develop unipolar or bipolar disorders. *European Archives of Psychiatry and Clinical Neuroscience, 243*, 340-346.

Cloninger, C.R. & Cloninger, K.M. (2011). Person-centered therapeutics. *International Journal of Person Centered Medicine, 1*, 43-52.

Cloninger, C.R., & Svrakic, D.M. (1997). Integrative psychobiological approach to psychiatric assessment and treatment. *Psychiatry: Interpersonal and Biological Processes, 60*, 120-141.

Cloninger, C.R., Bayon, C., & Svrakic, D.M. (1998). Measurement of temperament and character in mood disorders: a model of fundamental states as personality types. *Journal of Affective Disorders, 51*, 21-32.

Cloninger, C.R., Svrakic, D.M., & Przybeck, T.R. (1993). A psychobiological model of temperament and character. *Archives of General Psychiatry, 50*, 975-990.

Coffey, K.A., & Hartman, M. (2008). Mechanisms of action in the inverse relationship between mindfulness and psychological distress. *Complementary Health Practice Review, 13*, 79-91.

Corcoran, K.M., & Segal, Z.V. (2008). Metacognition in depressive and anxiety disorders: current directions. *International Journal of Cognitive Therapy, 1*, 33- 44.

Corr, P.J., & Matthews, G. (Eds.) (2009). *The Cambridge handbook of personality psychology*. Cambridge University Press.

Corsini, R.J., & Wedding, D. (2012). *Current psychotherapies*. Kaknüs Press, İstanbul. (in Turkish)

Costa, Jr. P.T., & McCrae, R.R. (1994b). Set like plaster? Evidence for the stability of adult personality. Heatherton TF, Weinberger JL (Eds) *Can personality change?* (pp. 21-40), Washington: American Psychological Association.

Costa, P.T., & McCrae, R. (1990). Personality Disorders and The Five-Factor Model of Personality. *Journal of Personality Disorders,* 4, 362-371.

Costa, P.T., McCrae, R.R. (1995). Domains and Facets: Hierarchical Personality Assessment Using the Revised NEO Personality Inventory. *Journal of Personality Assessment, 64*, 21-50.

Côté, S., Moskowitz, D.S. (1998). On the dynamic covariation between interpersonal behavior and affect: prediction from neuroticism, extraversion, and agreeableness. *Journal of Personality and Social Psychology, 75*, 1032.

Crane, R. (2009). *Mindfulness-Based Cognitive Therapy.* Taylor & Francis e-Library

D'Ambrosio, V., Albert, U., Bogetto, F., & Maina, G. (2010). Obsessive–compulsive disorder and cyclothymic temperament: An exploration of clinical features. *Journal of affective disorders, 127*, 295-299.

Davison, G.C., & Neale, J.M. (2007). *Abnormal Psychology, Study Guide*. (7th edition), Turkish Psychological Association, Ankara. (in Turkish).

Donnellan, M.B., & Lucas, R.E. (2008). Age differences in the Big Five across the life span: evidence from two national samples. *Psychology and Aging, 23*, 558.

Dumont, F., & Corsini, R.J. (2000). *Six therapists and one client*. New York: Springer Pub Co.

Ellis, A. (1969). Rational-emotive therapy. *Journal of Contemporary Psychotherapy*, *1*, 82-90.

Ellis, A. (1980). Rational-emotive therapy and cognitive behavior therapy: Similarities and differences. *Cognitive Therapy and Research*, *4*, 325-340.

Erskine, R.G., & Moursund, J. (2011). *Integrative psychotherapy in action.* Karnac Books.

Erten, Y., Mitrani, N., Tanık, M. (Eds) (2004). *The other side of psychoanalysis:Heinz Kohut* (Vol. 3). Ithaki Publishing. (In Turkish)

Fassino, S., Abbate-Daga, G., Pierò, A., Leombruni, P., & Rovera, G.G. (2003). Dropout from brief psychotherapy within a combination treatment in bulimia nervosa: role of personality and anger. *Psychotherapy and Psychosomatics, 72*, 203-210.

Ferenczi, S. (1994). *Further contributions to the theory and technique of psycho-analysis*. Karnac Books.

Freud, A. (1946). *The psycho-analytical treatment of children.*

Freud, S., & Bruer, J. (2001). *Studies in Hysteria*. Kapkın, E. (trans). İstanbul: Payel Press.

Garland, E.L. (2007). The meaning of mindfulness: a second order cybernetics of stres, metacognition and coping. *Complementary Health Practice Review, 12*, 15-30.

Gilbert, P., & Leahy, R.L. (eds) (2007). *The therapeutic relationship in the cognitive behavioral psychotherapies*. UK: Routledge.

Goldsmith, H.H., Buss, A.H., Plomin, R., Rothbart, M.K., Thomas, A., et al. (1987). Roundtable: What is temperament? Four Approaches. *Child Development, 58*, 505-529.

Halvorsen, M., Wang, C.E., Richter, J., Myrland, I., Pedersen, S.K., Eisemann, M., & Waterloo, K. (2009). Early maladaptive schemas, temperament and character traits in clinically depressed and previously depressed subjects. *Clinical Psychology & Psychotherapy, 16*, 394-407.

Harnic, D., Pompili, M., Mazza, M., Innamorati, M., Di Nicola, M., Catalano, V., & Janiri, L. (2013). Affective temperaments and psychopathological dimensions of personality in bipolar and cyclothymic patients. *Behavioral Medicine, 39*, 17-23.

Hartmann, H., & Rapaport, D.T. (1958). *Ego psychology and the problem of adaptation*.

Hawke, L.D., & Provencher, M.D. (2011). Schema theory and schema therapy in mood and anxiety disorders: A review. *Journal of Cognitive Psychotherapy, 25*, 257-276.

Hayes, A.M., & Feldman, G. (2004). Clarifying the construct of mindfulness in the context of emotion regulation. *Clinical Psychology: Science and Practice, 11*, 255-262.

Heinonen, E., Lindfors, O., Laaksonen, M.A., & Knekt, P. (2012). Therapists' professional and personal characteristics as predictors of outcome in short-and long-term psychotherapy. *Journal of Affective Disorders, 138*, 301-312.

Hellerstein, D.J., Kocsis, J.H., Chapman, D., Stewart, J.W., & Harrison, W. (2000). Double-blind comparison of sertraline, imipramine, and placebo in the treatment of dysthymia: effects on personality. *The American Journal of Psychiatry, 157*, 1436-44.

Hersen, M., & Seledge, W. (eds) (2002). *Encyclopedia of psychotherapy.* USA: Academic Press.

Horney, K., & Horney, K. (2013). *New ways in psychoanalysis* (Vol. 16). UK: Routledge.

Hranov, L.G., Marinova, P., Stoyanova, M., Pandova, M., & Hranov, G. (2013). Bipolar disorder-from endophenotypes to treatment. *Psychiatria Danubina, 25*, 284-291.

Hyer, L., & Brandsma, J.M. (1997). EMDR minus eye movements equals good psychotherapy. *Journal of Traumatic Stress, 10*, 515-522.

Joyce, P.R., Mckenzie, J.M., Carter, J.D., Rae, A.M., Luty, S.E., Frampton, C.M., & Mulder, R.T. (2007). Temperament, character and personality disorders as predictors of response to interpersonal psychotherapy and cognitive–behavioural therapy for depression. *The British Journal of Psychiatry, 190*, 503-508.

Jung, C.G. (1981). *The archetypes and the collective unconscious* (No. 20). USA: Princeton University Press.

Jung, C.G., & Walsh, M. (1987). *CG Jung speaking: Interviews and encounters.* McGuire, W., & Hull, R.F.C. (Eds.). Tertiary Resource Service, Royal Victorian Institute for the Blind.

Kaneda, A., Yasui-Furukori, N., Nakagami, T., Sato, Y., & Kaneko, S. (2011). The influence of personality factors on paroxetine response time in patients with major depression. *Journal of Affective Disorders, 135*, 321-325.

Kaplan, H.I., & Sadock, B.J. (2007). *Comprehensive textbook of psychiatry,* Güneş Press. (in Turkish).

Kline, F.M. (1980). Temperament styles in adult inter-actıon: applications in psychotherapy. New York City, *Psychiatric Services*, *31*, 423-424.

Korkut, F. (1992). The affect of individual counselling based on Gestalt approach on chronic anxiety. *Hacettepe University Education Faculty Journal*, 7. (in Turkish).

Köroğlu, E. (2008). *Rational emotive behavior therapy*. Ankara: HYB Press. (in Turkish).

Krueger, R.F., Caspi, A., Moffitt, T.E., White, J., & Stouthamer-Loeber, M. (1996). Delay of Gratification, Psychopathology, and Personality: Is Low Self-Control Specific to Externaiizing Problems? *Journal of Personality, 64*, 107-129.

Lafferty, P., Beutler, L.E., & Crago, M. (1989). Differences between more and less effective psychotherapists: a study of select therapist variables. *Journal of Consulting and Clinical Psychology*, *57*, 76.

Lynch, T.R., & Bronner, L.L. (2006). *Mindfulness and Dialectical Behaviour Therapy: application with depressed older adults with personality disorders.* Mindfulness and Acceptance Based Treatment Approaches, Baer, R. (ed), USA: Academic Press.

Lyoo, I.K., Yoon, T., Kang, D.H., & Kwon, J.S. (2003). Patterns of changes in temperament and character inventory scales in subjects with obsessive–compulsive disorder following a 4-month treatment. *Acta Psychiatrica Scandinavica,* 107, 298–304.

Maltby, J., Day, L., & Macaskill, A. (2010). *Personality, individual differences and intelligence.* Pearson Education.

Marchesi, C., Cantoni, A., Fontò, S., Giannelli, M.R., & Maggini, C. (2006). The effect of temperament and character on response to selective serotonin reuptake inhibitors in panic disorder. *Acta Psychiatrica Scandinavica, 114*, 203-10.

Marmor, J. (1979). Short-term dynamic psychotherapy. *The American Journal of Psychiatry*.

Maslow, A.H. (1943). A theory of human motivation. *Psychological Review*, *50*, 370.

May, R. (1958). *Contributions of existential psychotherapy.*

May, R., Angel, E., & Ellenberger, H. (1958). *Existence: A new dimension in psychology and psychiatry*. New York: Basic.

McCrae, R.R., & Costa, P.T. (1994a). The stability of personality: Observations and evaluations. *Current Directions in Psychological Science,* 173-175.

McCrae, R.R., & John, O.P. (1992). An introduction to the five-factor model and its applications. *Journal of Personality, 60*, 175-215.

Miller, L. (1993). Who are the best psychotherapists? Qualities of the effective practitioner. *Psychotherapy in Private Practice, 12*, 1-18.

Mitmansgruber, H., Beck, T.N., Höfer, S., & Schüßler, G. (2009). When you don't like what you feel: experiential avoidance, mindfulness and meta-emotion in emotion regulation. *Personality and Individual Differences, 46*, 448- 453.

Molnar, A., & Shazer, S. (1987). Solutıon-focused therapy: toward the identification of therapeutic tasks. *Journal of Marital and Family Therapy, 13*, 349-358.

Moreno, J.L. (1946). *Psychodrama without words*.

Mroczek, D.K., & Spiro, A. (2003). Modeling intraindividual change in personality traits: Findings from the Normative Aging Study. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 58*, 153-165.

Muran, C.J. (2007). *Dialogues on Difference Studies of Diversity in the Therapeutic Relationship.* Washington, DC: American Psychological Association.

Muris, P., & Ollendick, T.H. (2005). The role of temperament in the etiology of child psychopathology. *Clinical Child and Family Psychology Review, 8*, 271-289.

Nigg, J.T., John, O.P., Blaskey, L.G., Huang-Pollock, C.L., Willicut, E.G., Hinshaw, S.P., & Pennington, B. (2002). Big five dimensions and ADHD symptoms: links between personality traits and clinical symptoms. *Journal of Personality and Social Psychology, 83*, 451.

Ögel, K. (2012). *Therapies based on awareness and acceptance,* Ankara: Publication Union of Physicians Press. (in Turkish).

Palmer, S. (ed.) (2000). *Introduction to Counseling and Psychotherapy: The Essential Guide.* USA: Sage Press.

Paris, J. (2000). *Myths of Childhood.* UK: Psychology Press.

Perls, F.S. (1969). *Ego, Hunger and Aggression: The beginning of Gestalt Therapy*. New York, USA: Crown Publishing Group/ Random House.

Racker, H. (1957). The meanings and uses of countertransference. *The Psychoanalytic Quarterly.*

Rafaeli, E., Berstein, D.P., & Young, J.E. (2013). *Schema Therapy.* İstanbul: Psikonet Press. (in Turkish).

Rantanen, J., Metsäpelto, R.L., Feldt, T., Pulkkinen, L.E.A., & Kokko, K. (2007). Long-term stability in the Big Five personality traits in adulthood. *Scandinavian Journal of Psychology, 48*, 511-518.

Rapaport, D. (1951). The conceptual model of psychoanalysis. *Journal of Personality, 20*, 56-81.

Rettew, D.C., Doyle, A.C., Kwan, M., Stanger, C., & Hudziak, J.J. (2006). Exploring the boundary between temperament and generalized anxiety disorder: a receiver operating characteristic analysis. *Journal of Anxiety Disorders, 20*, 931-945.

Roberts, B.W., Walton, K.E., & Viechtbauer, W. (2006). Personality traits change in adulthood: Reply to Costa and McCrae. *Psychological Bulletin*, *132*, 29-32.

Roemer, L., Lee, J.K., Salters-Pedneault, K., Erisman, S. M., Orsillo, S. M., & Mennin. (2008). Mindfulness and emotion regulation difficulties in generalized anxiety disorder: Preliminary Evidence for Independent and Overlapping Contributions. *Behavior Therapy, 40*,142-154.

Rogers, C. (2012; 1961). *On becoming a person: A therapist's view of psychotherapy*. Houghton Mifflin Harcourt.

Rovai, L., Maremmani, A.G., Rugani, F., Bacciardi, S., Pacini, M., Dell'osso, L., et al. (2013). Do Akiskal & Mallya's affective temperaments belong to the domain of pathology or to that of normality? *European Review for Medical and Pharmacological Sciences, 17*, 2065-79.

Sato, T., Hirano, S., Narita, T., Kusunoki, K., Kato, J., Goto, M., et al. (1999). Temperament and character inventory dimensions as a predictor of response to antidepressant treatment in major depression. *Journal of Affective Disorders*, *56*, 153-61.

Serafini, G., Pompili, M., Innamorati, M., Fusar-Poli, P., Akiskal, H.S., Rihmer Z, et al. (2011). Affective temperamental profiles are associated with white matter hyperintensity and suicidal risk in patients with mood disorders. *Journal of Affective Disorders, 129*, 47-55.

Smith, D. (1982). Trends in counseling and psychotherapy. *American Psychologist*, *37*, 802.

Strelau, J. (2002). *Temperament a Psychological Perspective.* New York, USA: Kluwer Academic Publishers,

Strupp, H.H. (1978). *Psychotherapy research and practice: An overview.* Handbook of psychotherapy and behavior change, *2*, 3-22.

Strupp, H.H. (1995). The Psychotherapist's Skills Revisited. *Clinical Psychology: Science and Practice*, *2*, 70-74.

Svrakic, D.M., Draganic, S., Hill, K., Bayon, C., Przybeck, T.R., & Cloninger, C.R. (2002). Temperament, character, and personality disorders: etiologic, diagnostic, treatment issues. *Acta Psychiatrica Scandinavica*, *106*, 189-195.

Svrakic, D.M., Whitehead, C., Przybeck, T.R., & Cloninger, C.R. (1993). Differential diagnosis of personality disorders by the seven-factor model of temperament and character. *Archives of General Psychiatry, 50*, 991.

Tart, C.T., & Deikman, A.J. (1991). Mindfulness, spiritual seeking and psychotherapy. *The Journal, 23*, 29.

Thomas, A. (1968). *Temperament and behavior disorders in children*.

Toneatto, T. (2002). A metacognitive therapy for anxiety disorders: buddhist psychology applied, *Cognitive and Behavioral Practice, 9*, 72-78.

Tosone, C. (1997). Sändor Ferenczi: Forerunner of Modern Short-Term Psychotherapy. *Journal of Analytic Social Work, 4*, 23-41.

Türkçapar, M.H. (2008). *Cognitive therapy* (3stedn), Ankara: HYB Press. (in Turkish).

Ulman, E., & Dachinger, P. (1996). *Art Therapy in Theory & Practice.* Chicago, USA: Magnolia Street Publishers.

Wachtel, P.L. (1994). Cyclical processes in personality and psychopathology. *Journal of Abnormal Psychology, 103*, 51.

Weissman, M.M., & Markowitz, J.C. (1994). Interpersonal psychotherapy: Current status. *Archives of General Psychiatry*, *51*, 599-606.

Weissman, M.M., Markowitz, J.C., & Klerman, G. (2008). *Comprehensive guide to interpersonal psychotherapy*. Basic Books.

Wells, A. (2002). GAD, metacognition, and mindfulness: an information processing analysis. *Clinical Psychology: Science and Practice, 9*, 95-100.

Wiggins, J.S. (1997). In defence of traits. Hogan, R., Johnson, J.A., Briggs, S.R. (Eds.) *Handbook of personality psychology.* Elsevier.

Williams, J.M.G., Duggan, D.S., Crane, C., & Fennell, M.J. (2006). Mindfulness-Based cognitive therapy for prevention of recurrence of suicidal behavior. *Journal of Clinical Psychology, 62*, 201-210.

Yalom, I.D. (1980). *Existential psychotherapy.* Basic Books.

Yılmaz, E.D. (2010). *Personality and character development of children according to nine types temperament model.* Istanbul: Hayat Publishing (in Turkish).

Yılmaz, E.D., Gençer, A.G., & Aydemir, Ö. (2011). Evolution of a historical system to a new temperament model: Nine types temperament model. *Anatolian Journal of Psychiatry, 12*, 165-166.

Yılmaz, E.D., Gençer, A.G., Aydemir, Ö., Yılmaz, A., Kesebir, S., et al. (2014a). Reliability and validity of nine types temperament scale. *Education and Science, 39*, 115-137.

Yılmaz, E.D., Gençer, A.G., Ünal, Ö., &Aydemir, Ö. (2014b). From enneagram to nine types temperament model: A proposal. *Education and Science*, *39*, 393-415.

Yılmaz, E.D., Gençer, A.G., Ünal, Ö., Örek, A., Aydemir, Ö., Deveci, E., & Kırpınar, İ. (2015). The relationship between Nine Types Temperament Model with Psychobiological Personality Model and Affective Temperament Model. *Anatolian Journal of Psychiatry, 16*, 95-103. (in Turkish)

Young, J.E. (1994). *Cognitive therapy for personality disorders: A schema-focused approach.* Professional Resource Press/ Professional Resource Exchange.

Young, J.E., Klosko, J.S., & Weishaar, M.E. (2003). *Schema therapy: A practitioner's guide.* New York, USA: Guilford Press.

Young, J.E., Kolosko, J.S., & Weishaar, M.E. (2008). *Schema therapy,* İstanbul: Litera Press. (in Turkish).

Zeine, F. (2014). Awareness Integration: A New Therapeutic Model, *International Journal of Emergency Mental Health and Human Resilience*, *16*, 60-65.