PART ONE

CHAPTER 1

The Wisdom of Personalized Therapy

Introduction

Are not all psychotherapies personalized? Do not all therapists concern themselves with the person who is the patient they are treating? What justifies our appropriating the name "personalized" to the treatment approach we espouse? Are we not usurping a universal, laying claim to a title that is commonplace, routinely shared, and employed by most (all?) therapists?

We think not. In fact, we believe most therapists only incidentally or secondarily attend to the *specific personal qualities* of their patients. The majority come to their treatment task with a distinct if implicit bias, a preferred theory or technique they favor, one usually encouraged, sanctioned, and promoted in their early training, be it cognitive, group, family, eclectic, pharmacologic, or what have you.

How does our therapeutic approach differ? In essence, we come to the treatment task not with a favored theory or technique, but giving center stage to the patient's unique constellation of personality attributes. *Only after* a thorough evaluation of the nature and prominence of these personal attributes do we think through which combination and sequence of treatment orientations and methodologies we should employ.

As noted in the preface, "personalized" is not a vague concept or a platitudinous buzzword in our approach, but an explicit commitment to focus first and foremost on the unique composite of a patient's psychological makeup, followed by a precise formulation and specification of therapeutic rationales and techniques suitable to remedying those personal attributes that are assessed as problematic.

We have drawn on two concepts from our earlier writings, namely, personality-guided therapy (Millon, 1999) and synergistic therapy (Millon, 2002), integrating them into what we have now labeled "personalized psychotherapy." Both prior concepts remain core facets of our current treatment formulations in that, first, they are *guided* by the patient's overall personality makeup and, second, they are methodologically

synergistic in that they utilize a combinational approach that employs reciprocally interacting and mutually reinforcing treatment modalities that produce a greater total result than the sum of their individual effects.

The preface recorded a parallel "personalized" approach to physical treatment in what is called *genomic medicine.* Here medical scientists have begun to investigate a particular patient's DNA so as to decipher and remedy existing, missing, or broken genes, thereby enabling the physician to tailor treatment in a highly personalized manner, that is, specific to the underlying or core genetic defects of that particular patient. Anomalies that are etched into a patient's unique DNA are screened and assessed to determine their source, the vulnerabilities they portend, and the probability of the patient's succumbing to specific manifest diseases.

Personalized psychological *assessment* is *therapy-guiding;* it undergirds and orients personalized psychotherapy. Together, they should be conceived as corresponding to genomic medicine in that they seek to identify the unique constellation of *underlying vulnerabilities* that characterize a particular mental patient and the consequent likelihood of his or her succumbing to specific mental clinical syndromes. In personalized assessment (Millon, Bloom, & Grossman, in press) we seek to employ *customized instruments,* such as the Grossman Facet Scales of the Millon Clinical Multiaxial Inventory (MCMI-III), to identify the patient's vulnerable psychic domains (e.g., cognitive style, interpersonal conduct). These assessment data furnish a foundation and a guide for implementing the distinctive individualized goals we seek to achieve in personalized psychotherapy.

As will be detailed in later sections, we have formulated eight personality components or domains constituting what we term a *psychic DNA,* a framework that conceptually parallels the four chemical elements composing biologic DNA. Deficiencies, excesses, defects, or dysfunctions in these psychic domains (e.g., mood/temperament, intrapsychic mechanisms) effectively result in a spectrum of 15 manifestly different variants of personality pathology (e.g., Avoidant Disorder, Borderline Disorder). It is the unique constellation of vulnerabilities as expressed in and traceable to one or several of these eight potentially problematic psychic domains that becomes the object and focus of personalized psychotherapy (in the same manner as the vulnerabilities in biologic DNA result in a variety of different genomically based diseases).

The reader may wish to glance ahead to pages 28–30 in this chapter and review Figures 1.1, 1.2, and 1.3, as well as survey the assessment tables that detail the Millon-Grossman Personality Domain Checklist (pp. 50–68) to gain a more complete picture of the elements composing these vulnerable psychic domains and their associated 15 personality style/disorder spectra.

Reflections on Psychotherapeutic Practice Today

As we look back over the long course of scientific history we see patterns of progress and regress, brilliant leaps alternating with foolish pursuits and blind stumblings.

Significant discoveries often were made by capitalizing on accidental observation; at other times, progress required the clearing away of deeply entrenched but erroneous beliefs.

As the study of the sciences of psychopathology and psychotherapy progressed, different and occasionally insular traditions and terminology evolved to modify these beliefs. Separate disciplines with specialized educational and training procedures developed, until today we have divergent professional groups involved in the enactment of psychotherapy, for example, the medically oriented psychiatrist with his tradition in biology and physiology; the psychodynamic psychiatrist with her concern for unconscious intrapsychic processes; the clinical-personology psychologist with his interest in cognitive functions and the measurement of personality; and the academic psychologist with her experimental approaches to the basic processes and modification of behavior. Each has studied these complex questions with a different emphasis and focus. Yet the central issues remain the same.

Beset with troublesome "mental" difficulties, patients are given a bewildering "choice" of therapeutic alternatives that might prove emotionally upsetting in itself, even to the well-balanced individual. Thus, patients may not only be advised to purchase this tranquilizer rather than that one, or told to take vacations or leave their job or go to church more often, but if they explore the possibilities of formal psychological therapy, they must choose among myriad schools of treatment, each of which is claimed by its adherents to be the most efficacious, and by its detractors to be both unscientific and ineffective.

Should patients or their family evidence a rare degree of "scientific sophistication," they will inquire into the efficacy of alternative therapeutic approaches. What they will learn, assuming they chance upon an objective informant, is that the outcome of different treatment approaches is strikingly similar, and that there are few data available to indicate which method is "best" for the particular difficulty they face. Moreover, they will learn the troublesome fact that many patients improve *without benefit of psychotherapy.*

This state of affairs is most discouraging. However, the science, as opposed to the art, of psychotherapy is relatively new, perhaps no older than 3 or 4 decades. Discontent concerning the shoddy empirical foundations of therapeutic practices was registered in the literature as early as 1910 (Patrick & Bassoe, 1912), but systematic research did not begin in earnest until the early 1950s and has become a primary interest of able investigators only in the past 30 to 40 years (Bergen & Garfield, 1994; Drake, Merrens, & Lynde, 2005; Fisher & O'Donohue, 2006; Frank & Frank, 1991; A. P. Goldstein & Dean, 1966; Goodheart, Kazdin, & Sternberg, 2006; Gottschalk & Auerbach, 1966; Hoch & Zubin, 1964; Lazarus & Messer, 1991; Nathan & Gorman, 2002; Norcross & Goldfried, 1992; Rubinstein & Parloff, 1959; Shlien, 1968; Stollak, Guerney, & Rothberg, 1966; Strupp & Luborsky, 1962).

The varied settings, goals, processes, and orientation that differentiate psychological treatment methods may lead one to conclude that the field of psychotherapy comprises a motley assemblage of techniques. However, despite substantive differences in

verbalized rationales and technical procedures, psychotherapies sound more dissimilar than they are in practice. Close inspection reveals that the aims of many are fundamentally alike and that their methods, although focusing on different facets or levels of psychological functioning, deal essentially with similar pathological processes.

It should be noted that psychotherapy is a constantly changing science of treatment. As new research, theory, and clinical experience enlarge our range of knowledge, many of the treatment techniques described in this and the associated books of this series may call for modification. These personalized psychotherapeutic texts are intended exclusively for graduate students and clinical professionals; moreover, the reader is not expected to utilize their suggestions without an extensive range of information about a specific patient to guide his or her treatment. Although every effort has been made to furnish guidelines that live up to medical and psychological standards, the authors cannot make any warranty as to the effectiveness of the methods contained herein. This caveat is especially addressed to nonprofessionals who may be seeking methods for self-treatment: nonprofessionals are urged to consult their psychologist and/or physician for advice and treatment.

As noted, psychotherapy has been dominated until recently by what might be termed domain- or modality-oriented therapy. That is, therapists identified themselves with a single-realm focus or a theoretical school (behavioral, intrapsychic) and attempted to practice within whatever prescriptions for therapy it made. Rapid changes in the therapeutic milieu, all interrelated through economic pressures, conceptual shifts, and diagnostic innovations, have taken place in the past few decades. For better or worse, these changes show no sign of decelerating and have become a context to which therapists, far from reversing, must now themselves adapt.

Ironically, changes wrought by the confluence of economics, the diagnostic revolution that began with the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*), the increasing awareness of minority- and gender-related issues, and the managed care revolution in the 1980s perhaps represent an accidental example of the emergent synergism for which the authors believe therapists should strive in their everyday work. Alone, the reinvention of the form and substance of the official nosology that occurred with the *DSM-III* in 1980 probably would not have been enough to overturn domain- or school-oriented psychotherapy, though certainly the emancipation of the *DSM* from the psychodynamic paradigm, and in favor of an atheoretical posture, did in fact hold the philosophical seeds of the recent coup that followed. Nonetheless, it may be argued that the essential force that provided, and continues to provide, the latent agenda for therapeutic innovation came from without, in the form of reluctance on the part of almost all third-party payers to reimburse psychosocially grounded psychotherapy. The study of such economic influences—through which the substance of what a discipline postures as truth changes to conform with new requirements for its continued existence—is worthy of a treatise in itself. Here, however, we sketch only a few broad strokes.

Today it is economic forces, not theoretical developments or evidence-based empirical research, that increasingly drive the direction of developments in psychotherapy.

Although modern times continue to see an explosion in the total number of all therapies, it is the demands of managed care that require an accounting of the efficacy of more inclusive therapies. The message to psychotherapists today is "Do more with less," meaning, unfortunately, not only fewer sessions, but more patients, and therefore less time spent thinking about the dynamics of any one patient's problems. The emphasis on efficiency is today the primary impetus in the development of programmatic forms of therapy across the spectrum of disorders. Moreover, these forms have been adapted to variables at levels of analysis congruent with what is afforded by current economic constraints. So therapy becomes more behavioral and operational and less dynamic and inferential.

Trend toward Briefer and Evidence-Based Therapies

Whatever the economic constraints, psychopathology would seem to stand squarely and intrinsically in opposition, not just to managed therapies, but to most forms of brief and research-evaluated therapy. The more concentrated Axis I disorders do admit to more focal, and therefore briefer, more explicit interventions. The disorders of Axis II, however, essentially more long-standing and pervasive disorders constituting the entire matrix of the patient, may stand like stone monoliths unmoved in the face of these fiscal demands.

Is it reasonable to expect 10, or even fewer, hours with a therapist to "cure" such complex disorders? These disorders are not clay to be passively resculpted. Functioning in a manner similar to the immune system, the psychic system actively resists any external influence that would disrupt its homeostasis. To uproot a complex disorder, one must wrangle with the ballast of a lifetime, a developmental pathology that has grown to become the entire structure of the person, manifested and perpetuated across a lifetime. By any reasoning, the pervasiveness and entrenched tenacity of the psychic pathology is likely to soak up therapeutic resources without end, leading inevitably to pessimism and disaffection for both therapists and payers.

The general term "brief therapy" encompasses a wide range of approaches, techniques, and philosophical orientations, often obscuring important elements more than it may actually reveal. Similarly, despite its relative recency, segments signifying brief approaches to treatment can be traced back to the earliest of therapeutic efforts at the beginning of the twentieth century (Millon, 1999).

Trend toward Culturally Sensitive Therapies

Psychotherapists are faced with an increasing challenge of cultural diversity and gender issues in their work in Western societies. The profession has been remiss in taking cognizance of these factors in the past, displaying indifference, neglect, or inadequate preparation in our graduate training programs and in our daily practice. The part that these sociocultural issues play in our work has become more fully recognized in recent times. Numerous books and papers on socially relevant topics have been published this past decade; many compensate for the almost pernicious character of our multicultural insensitivities of the past. Fortunately, the special roles and perspectives required on

the part of therapists dealing with increasingly diverse societal subgroups have become a significant trend in our professional work.

As in the past, the United States continues to be enriched by its *growing diversity of ethnic and racial minorities.* A transformation is rapidly taking place in our society. Close to 80% of those entering the United States and its labor force are composed of minorities, drawn from a vast arena of other countries and cultures. Further, owing to the fact that the fertility rate of the dominant American culture has been declining and that the newborn population of ethnic/racial minorities continues to grow, it is clear that minority groups will become the numerical majority by midcentury. This trend calls for an important reassessment of our traditional therapeutic attitudes and responsibilities. Psychotherapists are only now being prepared for diverse patient populations with appreciably different cultural values and social experiences than has typified our practice in earlier years.

The core unit in the dominant American society is the nuclear family; here, parents live alone with their children, while other significant relatives (aunts, uncles, grandparents) live separately in independent family units. Many racial/ethnic subgroups, however, live in extended family systems, with diverse relatives of all ages living together or in very close proximity. Family therapy in our dominant social system tends to include only members of the nuclear family; other relatives are rarely brought into treatment. For example, the central role that grandparents have may be overlooked in treating Asian American families.

As a consequence of the diversity of racial/ethnic value systems, the primary orientation of many established therapeutic schools of thought may not prove as relevant and suitable as one might hope. We must recognize that the ancestry of many of the therapeutic theories we utilize is to be found in Western societal thought and, hence, reflects an English or European cultural perspective, with their implicit goals, values, and attitudes. The suitability, for example, of psychodynamic therapy is questionable owing to its focus on the key role of the individual, the desire to aid the person "to know oneself," to recognize that the problem that faces the patient is one that inheres within himself, with the consequent task of working through intrapsychic or unconscious mental distortions. This contrasts sharply with minority patient values and experiences in which primary attention may best be placed on the key role of sociocultural factors, such as racism, poverty, and social marginality. Similarly, the orientation in cognitive approaches stresses thought distortions that undermine the patient's effective functioning; in fact, the troublesome cognitions of the patient may represent the awful but actual realities experienced in everyday life. Similarly, self-actualizing modalities orient patients toward achieving psychic growth and self-esteem, but such an emphasis may cause considerable conflict or guilt for patients who come from cultural groups that are grounded in the importance of the collective, the family, or a traditional community.

Although the United States has benefited greatly these past 3 decades by the emergence of the feminist movement, especially as manifested in an *increase in women's rights and opportunities,* this valued progress has been a mixed blessing for some. For

both men and women, there is a deep struggle between the wish for mastery and self-determination, on the one hand, and the wish for protection and security, on the other. The feminist movement has sought to facilitate the development of women's autonomy, self-assertion, and psychic independence. This same ideal, however, is often experienced as a threat when it opposes the female tradition of deserving protection from the uncertainties of a complex and competitive world. Success and achievement, therefore, can be sources of discomfort, if not anxiety, because they may threaten to disrupt the fulfillment of conflicting life-nurturing needs. Despite the worthy values of the feminist movement, many women have been socialized not to master competitive tasks, but to develop social rather than professional skills. Behaviors that run contrary to traditional feminine roles are a special problem for women who often see their efforts at autonomy and achievement as a sign of rebelliousness, if not deviance in contemporary society.

Therapists have observed that women, in efforts to compete with men, often anticipate troublesome social consequences for their effort. Whereas men assume that success will lead to further opportunities and cultural rewards, women are often in conflict about achievement, such as feeling guilty about surpassing their mother, the fear of losing a less adequate male partner, and consequent anxieties about aloneness in a less-than-accepting world. Historically, female identity has been shaped to be pleasing to men and to downgrade women's own abilities and confidence. It has been difficult, therefore, to integrate a sense of work achievement as a source of one's self-identity.

No therapist would wish to return to the days when women were encouraged to be quiet and sedate, to be seen and not heard, to be obedient and passive. But on the other hand, good therapists must recognize that ours is a time of cultural transition, when countervailing voices are to be heard, hence creating internalized conflicts for many women who will come to seek their guidance and support. There is little doubt that part of the conflict that women face stems from a social system sharply divided in its attitudes. However, in a society in which women are denied equal access to opportunities and resources, it should be a priority of therapists to help resolve the conflicts in those able women who struggle with their role-breaking efforts to find a more egalitarian life that will enable them to synthesize their deeper emotional needs with the authenticity of autonomy and independence.

There is a growing receptiveness and open-mindedness in the United States today regarding the *diverse forms of gender proclivity and sexual preference.* Although this trend has numerous benefits for many, problematic residuals remain for some that may call for therapeutic action. Although gay men and lesbians are some 10 to 15% of the overall population in the United States, their status, until the past decade or so, has been that of an invisible minority. Pervasive negative attitudes in society and insufficient professional training have prevented the delivery of thoughtful and sensitive therapeutic services to this subculture group. The trend toward greater knowledge and more egalitarian attitudes has only recently led to increased knowledge and skills necessary to work effectively with these patients.

Gay people, both male and female, experience a unique position among the socially rejected groups in that they are reared largely in nongay families, families who fail to provide adequate models of self-respect and self-esteem and rarely provide an attitude of acceptance and affirmation for their progeny's socially problematic identity. Homophobia is commonplace and characterizes how most families and others react to gay people. Moreover, gay men and lesbians often grow up learning the same rejecting and hostile attitudes toward same-sex intimacies as do nongays. This internalization of homophobia is distressing for many gays, one that further complicates their already troubled self-identity.

The problems presented by gay persons are not unexpected. Typical is a young person who might come to a therapist because he has been degraded, if not beaten, by his family, has been thrown out of his home, and is now homeless. The most frequent presenting problem among young gays is that of isolation. Youngsters report having no one to talk to and feeling alone in most social situations, especially within the family, at school, or in their religious community. Such isolation is usually associated with their fear of discovery and the constant need to hide. Even where a network of gay social companions is available, there is often a sense that others are interested only in exploiting them. Not to be overlooked is a sense of deep emotional isolation, the belief that one cannot trust bonding or attaching to others owing to the assumption that the gay lifestyle tends to be transient and incidental rather than genuine and enduring. Lacking a consistent and appropriate role model, many young gays often demonstrate an appalling ignorance regarding what it is to be homosexual, frequently holding to the worst stereotypes about homosexuals—and therefore about themselves.

There is no reason to believe that the homosexually oriented, as a group, are less well-adjusted than their heterosexual counterparts, but there are specific factors that typify the problems that gays do experience when difficulties have arisen; isolation, family rejection, abuse, and intrapsychic identity conflicts represent the problems for which they seek guidance. The task of therapists is not invariably a complex one. Many gays simply need access to accurate information; others need opportunities for socialization with a wider network of peers than can be achieved in same-sex settings. Of course, it is extremely difficult for gays to "actualize" themselves in a social context of public rejection. Moreover, gays and lesbians need support before they can fully express themselves and their individuality. Therapists must also learn to feel comfortable with their own sexuality and seek to rid themselves of homophobic feelings if they are to work openly and honestly with gay and lesbian patients. Most important, they must aid their patients to be free of their own homophobic stereotypes and conflicts, enabling them to develop a healthier attitude toward their own genuine feelings and authentic identities.

As with all issues discussed in this section on minority, feminist, and gay/lesbian perspectives, most of the "standard" therapeutic approaches discussed in this chapter can be carefully examined so as to reorient underlying biases and assumptions. Most may thereby not only prove useful, but may be applied with an informed sensitivity to the patient's special life conditions.

Trend toward Integrative Therapies

The simplest way to practice psychotherapy is to approach all patients as possessing essentially the same disorder, and then utilize one standard modality of therapy for their treatment. Many therapists still employ these simplistic models. Yet everything we have learned in the past 2 or 3 decades tells us that this approach is only minimally effective and deprives patients of other, more sensitive and effective approaches to treatment. In the past 2 decades, we have come to recognize that patients differ substantially in the clinical syndromes and personality disorders they present. It is clear that not all treatment modalities are equally effective for all patients, be it pharmacologic, cognitive, intrapsychic, or another mode. The task set before us is to maximize our effectiveness, beginning with efforts to abbreviate treatment, to recognize significant cultural considerations, to combine treatment, and to outline an integrative model for selective therapeutics. When the selection is based on each patient's personal trait configuration, integration becomes what we have termed *personalized psychotherapy,* to be discussed in the next section.

Present knowledge about combinational and integrative therapeutics has only begun to be developed. In this section we hope to help overcome the resistance that many psychotherapists possess to the idea of utilizing treatment combinations of modalities that they have not been trained to exercise. Most therapists have worked long and hard to become experts in a particular technique or two. Though they are committed to what they know and do best, they are likely to approach their patients' problems with techniques consonant with their prior training. Unfortunately, most modern therapists have become expert in only a few of the increasingly diverse approaches to treatment and are not open to exploring interactive combinations that may be suitable for the complex configuration of symptoms most patients bring to treatment.

In line with this theme, Frances, Clarkin, and Perry (1984, p. 195) have written:

> The proponents of the various developing schools of psychotherapy tended to maintain the pristine and competitive purity of their technical innovations, rather than attempt to determine how these could best be combined with one another. There have always been a few synthesizers and bridge builders (often derided from all sides as "eclectic") but, for the most part, clinicians who were trained in one form of therapy tended to regard other types with disdain and suspicion.

The inclination of proponents of one or another modality of therapy to remain separate was only in part an expression of treatment rivalries. During the early phases of a treatment's development, innovators, quite appropriately, sought to establish a measure of effectiveness without having their investigations confounded by the intrusion of other modalities. No less important was that each treatment domain was but a single dimension in the complex of elements that patients bring to us. As we move away from a simple medical model to one that recognizes the psychological complexity of patients' symptoms and causes, it appears wise to mirror the patients' complexities by developing therapies that are comparably complex.

As will be elaborated throughout the text, certain combinational approaches have an additive effect; others may prove to possess a synergistic effect (Klerman, 1984). The term additive describes a situation in which the combined benefits of two or more treatments are at least equal to the sum of their individual benefits. The term synergistic describes a situation in which the combined benefits of several treatment modalities exceed the sum of their individual components; that is, their effects are potentiated. This entire book series is intended to show that several modalities—pharmacotherapy, cognitive therapy, family therapy, intrapsychic therapy—may be combined and integrated to achieve additive, if not synergistic effects.

It is our view that psychopathology itself contains structural implications that legislate the form of any therapy one would propose to remedy its constituents. Thus, the philosophy we present derives from several implications and proposes a new integrative model for therapeutic action, an approach that we have called *personalized psychotherapy.* This model, which is guided by the psychic makeup of a patient's personality—and not a preferred theory or modality or technique—gives promise, we believe, of a new level of efficacy and may, in fact, contribute to making therapy briefer. Far from being merely a theoretical rationale or a justification for adhering to one or another treatment modality, it should optimize psychotherapy by tailoring treatment interventions to fit the patient's specific form of pathology. It is not a ploy to be adopted or dismissed as congruent or incongruent with established therapeutic preferences or modality styles. Despite its name, we believe that what we have termed a personalized approach will be effective not only with Axis II personality disorders, but also with Axis I clinical syndromes, as illustrated in this first volume of the three-part series on the topic.

What exactly do we mean when we say that therapy must be integrated and should be grounded in the inherent characteristics of the patient (Arkowitz, 1992; Millon, 1988)? Unfortunately, much of what travels under the "eclectic" or "integrative" banner sounds like the talk of someone desiring to be nice to all sides and to say that everybody is right. These labels have become platitudinous buzzwords, philosophies with which open-minded people certainly would wish to ally themselves. But "integrative theory and psychotherapy" must signify more than that.

First, the approach to therapy that we propose is not eclecticism. Perhaps it might be considered posteclecticism, if we may borrow a notion used to characterize modern art just a century ago. Eclecticism is not a matter of choice. We all must be eclectics, engaging in differential (Frances et al., 1984) and multimodal (Lazarus, 1981) therapeutics, selecting the techniques that are empirically the most efficacious for the problems at hand (Beutler & Clarkin, 1990).

Integration should be more than the coexistence of two or three previously discordant orientations or techniques. We cannot simply piece together the odds and ends of several theoretical schemas, each internally consistent and oriented to different data domains. Such a hodgepodge will lead only to illusory syntheses that cannot long hold together (Messer, 1986, 1992). Efforts such as these, meritorious as they may be in some regards, represent the work of peacemakers, not innovators and not integrationists. Integration is eclectic, of course, but more.

As we will argue further, it is our belief that integration should be a synthesized system to mirror the problematic configuration of traits (personality) and symptoms (clinical syndromes) of a specific patient-at-hand. In the next section, we discuss integration from this view. Many in the past have sought to coalesce differing theoretical orientations and treatment modalities with interconnecting bridges. By contrast, those of us in the *personalized* therapeutic persuasion bypass the synthesis of theory. Rather, primary attention should be given to the *natural synthesis or inherent integration that may be found within patients* themselves.

As Arkowitz (1997) has noted, efforts to create a theoretical synthesis are usually not fully integrative in that most theorists do not draw on component approaches equally. Most are oriented to one particular theory or modality, and then seek to assimilate other strategies and notions to that core approach. Moreover, assimilated theories and techniques are invariably changed by the core model into which it has been imported. In other words, the assimilated orientation or methodology is frequently transformed from its original intent. As Messer (1992, p. 151) wrote, "When incorporating elements of other therapies into one's own, a procedure takes its meaning not only from its point of origin, but even more so from the structure of the therapy into which it is imported." Messer illustrates this point by describing a two-chair gestalt procedure that is brought into a primary social-learning model; in this assimilation, the two-chair procedure will likely be utilized differently and achieve different goals than would occur in the hands of a gestalt therapist using the same technique.

Furthermore, by seeking to impose a theoretical synthesis, therapists may lose the context and thematic logic that each of the standard theoretical approaches has built up over its history. In essence, intrinsically coherent theories are usually disassembled in the effort to interweave their diverse bits and pieces. Such an integrative model composed of alternative models (behavioral, psychoanalytic) may be pluralistic, but it reflects separate modalities with varying conceptual networks and their unconnected studies and findings. As such, integrative models *do not* reflect that which is inherent in nature, but *invent* a schema for interweaving that which is, in fact, essentially discrete.

As will be discussed in the following section, it is argued that intrinsic unity cannot be invented, but can be discovered in nature by focusing on the intrinsic unity of the person, that is, the full scope of a patient's psychic being. It will be asserted that integration based on the natural order and unity of the person avoids the rather arbitrary efforts at synthesizing disparate and sometimes disjunctive theoretical schemas.

Efforts at synthesizing therapeutic models have been most successful in desegregating the field rather than truly integrating it. As Arkowitz (1997, pp. 256–257) explains:

> Integrative perspectives have been catalytic in the search for new ways of thinking about and doing psychotherapy that go beyond the confines of single-school approaches. Practitioners and researchers are examining what other theories and therapies have to offer. . . .
>
> Several promising starts have been made in clinical proposals for integrative therapies, but it is clear that much more work needs to be done.

As noted, it is the belief of the authors that integration cannot stem from an intellectual synthesis of different theories, but from the inherent integration that is discovered in each patient's personal style of functioning, a topic to which we now turn.

Emergence of Personalized Psychotherapy

Unlike eclecticism, integration insists on the primacy of an overarching gestalt that gives coherence, provides an interactive framework, and creates an organic order among otherwise discrete units or elements. Whereas the theoretical syntheses previously discussed attempt to provide an intellectual bridge across several theories or modalities, personalized integrationists assert that a natural synthesis already exists within the patient. As we better understand the configuration of traits that characterize each patient's psyche, we can better devise a treatment plan that will mirror these traits and, we believe, will provide an optimal therapeutic course and outcome.

As noted previously, integration is an important concept in considering not only the psychotherapy of the individual case but also the place of psychotherapy in clinical science. For the treatment of a particular patient to be integrated, the elements of a clinical science—theory, taxonomy, assessment, and therapy—should be integrated as well (Millon, 1996b). One of the arguments advanced earlier against empirically based eclecticism is that it further insulates psychotherapy from a broad-based clinical science. In contrast to eclecticism, where techniques are justified empirically, *personalized psychotherapeutic integration* should take its shape and character from an integrative theory of human nature. Such a grand theory should be inviting because it attempts to explain all of the natural variations of human behavior, normal or otherwise; moreover, personalized psychotherapy will grow naturally out of such a personalized theory. Theory of this nature will not be disengaged from therapeutic technique; rather, it will inform and guide it.

Murray (1983) has suggested that the field must develop a new, higher order theory to help us better understand the interconnections among cognitive, affective, self, and interpersonal psychic systems. It is the belief of personalized therapeutic theorists, such as ourselves, who claim that interlinked configurations of pathology deduced from such a theory can serve to guide psychotherapy.

Although differential treatment gives special weight to the specific problem areas of the patient, most theorists and therapists pay little attention to the particular domains composing different diagnostic categories. We argue for considering the configuration of personality traits that characterize each specific patient. Differential treatment recognizes that current diagnostic information, such as listed in *DSM-IV,* provides only a surface coverage of the complex elements that are associated with a patient's inner and outer worlds.

As noted previously, whether we work with "part functions" that focus on behaviors, cognitions, unconscious processes, or biological defects, or whether we address contextual systems that focus on the larger environment, the family, the group, or the socioeconomic and political conditions of life, the crossover point, the place that links

parts to contexts, is the person. The individual is the intersecting medium that brings them together.

Persons, however, are more than crossover mediums. They are the only organically integrated system in the psychological domain, inherently created from birth as natural entities rather than experience-derived gestalts constructed via cognitive attribution. Moreover, it is persons who lie at the heart of the psychotherapeutic experience, the substantive beings that give meaning and coherence to symptoms and traits—be they behaviors, affects, or mechanisms—as well as those beings, those singular entities, that give life and expression to family interactions and social processes.

The cohesion (or lack thereof) of intrinsically interwoven psychic structures and functions is what distinguishes most complex disorders of psychopathology; likewise, the orchestration of diverse yet synthesized modalities of intervention is what differentiates synergistic from other variants of psychotherapy. These two parallel constructs, emerging from different traditions and conceived in different venues, reflect shared philosophical perspectives, one oriented toward the understanding of mental disorders, the other toward effecting their remediation.

It is not that one-modality or school-oriented psychotherapies are inapplicable to more focal or simple syndrome pathologies, but rather that synergistically planned therapies are required for the intricate relationships that interconnect personality and clinical syndromes (whereas depression may successfully be treated either cognitively or pharmacologically); it is the very interwoven nature of the components that compose such complex disorders that makes a multifaceted and synthesized approach a necessity.

In the following pages we present a few ideas in sequence. First, personalized therapies require a foundation in a coordinating theory of nature, that is, they must be more than a schema of eclectic techniques, a hodgepodge of diverse alternatives assembled de novo with each case. Second, although the diagnostic criteria that make up *DSM* syndromes are a decent first step, these criteria must become comprehensive and comparable, that is, be systematically revised so as to be genuinely useful for treatment planning. Third, a logical rationale can be formulated as to how one can and should integrate diverse modality-focused therapies when treating complex psychopathologies.

Broadening the Base of Personologic Science

Before turning to these themes, we would like to comment briefly on some philosophical issues. They bear on a rationale for developing a wide-ranging theory of nature to serve as a basis for treatment techniques, that is, universal principles that transcend the merely empirical (e.g., electroconvulsive therapy for depressives). It is our conviction that the theoretical foundations of our personologic science must be advanced further if we are to succeed in constructing a personalized approach to psychotherapy.

Obviously, a tremendous amount of knowledge, both about the nature of the patient's disorders and about diverse modes of intervention, is required to perform

personalized therapy. To maximize synergism among numerous modalities requires that the therapist be a little like a jazz soloist. Not only should the professional be fully versed in the various musical keys, that is, in techniques of psychotherapy that span all trait domains, but he or she should also be prepared to respond to subtle fluctuations in the patient's thoughts, actions, and emotions, any of which could take the composition in a wide variety of directions, and integrate these with the overall plan of therapy as it evolves. After the instruments have been packed away and the band goes home, a retrospective account of the entire process should reveal a level of thematic continuity and logical order commensurate with that which would have existed had all relevant constraints been known in advance.

The integrative processes of personalized therapy should be dictated by the nature of personality itself. The actual logic and foundation of this therapy, however, must be grounded on some other basis. Psychopathology is by definition a patterning of intraindividual variables, but the nature of these variables must be supplied by a set of fundamental principles or on some basis beyond the personologic construct. In our view, for example, the structure and functions of personality and psychopathology are grounded in evolutionary theory, a discipline that informs but exists apart from our clinical subject. In and of itself, pathologic personality is a structural-functional concept that refers to the intraorganismic patterning of variables; it does not in itself say what these variables are or how they relate, nor can it.

As stated previously (Millon, 1990, 2004), we believe that several elements characterize all mature clinical sciences: (a) They embody *conceptual theories* based on universal principles of nature from which their propositional deductions can be derived; (b) these theories provide the basis for *coherent taxonomies* that specify and characterize the central features of their subject domain (in our case, that of personality and psychopathology, the substantive realm within which scientific psychotherapeutic techniques are applied); (c) these taxonomies are associated with a variety of *empirically oriented assessment instruments* that can identify and quantify the concepts that constitute their theories (in psychopathology, methods that uncover developmental history and furnish cross-sectional assessments); and (d) in addition to natural theory, clinical taxonomy, and empirically anchored assessment tools, mature clinical sciences possess *change-oriented intervention* techniques that are therapeutically optimal in modifying the pathological elements of their domain.

Most current therapeutic schools share a common failure to coordinate these four components of a mature science. What differentiates them has less to do with their scientific grounding than with the fact that they attend to different levels of data in the natural world. It is to the credit of those of an eclectic persuasion that they have recognized, albeit in a fuzzy way, the arbitrary if not illogical character of single-focus positions, as well as the need to bridge schisms among these approaches that have evolved less by philosophical considerations or pragmatic goals than by the accidents of history (Millon, 2004). There are numerous other knotty issues with which the nature of psychic pathology and personalized therapy must contend (e.g., differing

worldviews concerning the essential nature of psychological experience). There is no problem, as we see it, in encouraging active dialectics among these contenders.

However, there are two important barriers that stand in the way of personalized psychotherapy as a treatment philosophy. The first is the *DSM.* The idea of diagnostic prototypes was a genuine innovation when the *DSM-III* was published in 1980. The development of diagnostic criteria work groups was intended to provide broad representation of various points of view, while preventing any single perspective from foreclosing on the others. Even some 25 years later, however, the *DSM* has yet to officially endorse an underlying set of principles that would interrelate and differentiate the categories in terms of their deeper principles. Instead, progress proceeds mainly by way of committee consensus, cloaked by the illusion of empirical research.

The second barrier is the human habit system. The admonition that different therapeutic approaches should be pursued with different patients and different problems has become almost self-evident. But given no logical basis from which to design effective therapeutic sequences and composites, even the most self-consciously antidogmatic clinician must implicitly lean toward one orientation or another.

What specifically are the procedures that distinguish personalized therapy from other models of an eclectic nature?

The integrative model labeled 2 decades ago by the senior author as "personologic psychotherapy" (Millon, 1988) insisted on the primacy of an overarching gestalt that gave coherence, provided an interactive framework, and created an organic order among otherwise discrete polarities and attributes. It was eclectic, but more. It was derived from a substantive theory whose overall utility and orientation derives from that old chestnut "The whole is greater than the sum of its parts." The problems our patients bring to us are often an inextricably linked nexus of interpersonal behaviors, cognitive styles, regulatory processes, and so on. They flow through a tangle of feedback loops and serially unfolding concatenations that emerge at different times in dynamic and changing configurations. Each component of these configurations has its role and significance altered by virtue of its place in these continually evolving constellations. *In parallel form, personalized therapy should be conceived as an integrated configuration of strategies and tactics in which each intervention technique is selected not only for its efficacy in resolving particular pathological attributes, but also for its contribution to the overall constellation of treatment procedures of which it is but one integral part.*

Although the admonition that we should *not* employ the same therapeutic approach with all patients is self-evident, it appears that therapeutic approaches accord more with where training occurred than with the nature of the patients' pathologies. To paraphrase Millon (1969/1985), there continues to be a disinclination among clinical practitioners to submit their cherished techniques to detailed study or to revise them in line with critical empirical findings. Despite the fact that most of our therapeutic research leaves much to be desired in the way of proper controls, sampling, and evaluative criteria, one overriding fact comes through repeatedly: Therapeutic techniques must be suited to the patient's problem. Simple and obvious though this statement is, it is

repeatedly neglected by therapists who persist in utilizing and argue heatedly in favor of a particular approach to *all* variants of psychopathology. No school of therapy is exempt from this notorious attitude.

Why should we formulate a personalized therapeutic approach to psychopathology? The answer may be best grasped if we think of the psychic elements of a person as analogous to the sections of an orchestra, and the trait domains of a patient as a clustering of discordant instruments that exhibit imbalances, deficiencies, or conflicts within these sections. To extend this analogy, therapists may be seen as conductors whose task is to bring forth a harmonious balance among all the sections, as well as their specifically discordant instruments, muting some here, accentuating others there, all to the end of fulfilling the conductor's knowledge of how the composition can best be made consonant. The task is not that of altering one instrument, but of altering all, in concert. What is sought in music, then, is a balanced score, one composed of harmonic counterpoints, rhythmic patterns, and melodic combinations. What is needed in therapy is a likewise balanced program, a coordinated strategy of counterpoised techniques designed to optimize sequential and combinatorial treatment effects.

If clinical syndromes were anchored exclusively to one particular trait domain (as phobias are thought of being primarily behavioral in nature), modality-bound psychotherapy would always be appropriate and desirable. Psychopathology, however, is not exclusively behavioral, cognitive, biologic, or intrapsychic, that is, confined to a particular clinical data level. Instead, it is multioperational and systemic. No part of the system exists in complete isolation. Instead, every part is directly or indirectly tied to every other, such that a synergism lends the whole a tenacity that makes the full system of pathology "real"—a complex that needs to be fully reckoned with in a comprehensive therapeutic endeavor. Therapies should mirror the configuration of as many trait and clinical domains as the syndromes and disorders they seek to remedy. If the scope of the therapy is insufficient relative to the scope of the pathology, the treatment system will have considerable difficulty fulfilling its meliorative and adaptive goals. Both unstructured intrapsychic therapy and highly structured behavioral techniques, to note the extremes, share this deficiency.

Most psychotherapists have had the unsettling experience of developing a long-term treatment plan, only to have the patient make some startling revelation several sessions later, requiring a significant change of course. Although some therapists will always administer the same form of therapy regardless of the problem, a good theory should allow techniques across many modalities to be dynamically adapted or integrated as ongoing changes in the patient occur or as new information comes to light.

In contrast to this ideal, the state of the art in psychotherapy can be characterized as either linear, but dogmatic, or eclectic, but uncoordinated. Linear perspectives hail mainly from the historical schools that have dominated psychotherapy's classical past. Major viewpoints include the psychodynamic, interpersonal, neurobiological, behavioral, and cognitive, but more esoteric conceptions could also be included, such as the existential, phenomenological, cultural, and perhaps even religious. Theorists

within each perspective usually maintain that their content area is core or fundamental and thus serves as the logical basis for the treatment of its disorders. In the earlier, dogmatic era of therapeutic systems, psychologists strongly wedded to a particular perspective would either assert that other points of view were peripheral to their own pet contents, or just stubbornly ignore the existence of other schools of thought. Behaviorists, for example, denied the existence of the mental constructs, including self and personality. In contrast, psychodynamic psychologists held that behavior is useful only as a means of inferring the properties and organization of various mental structures, namely, the id, ego, and superego, and their "drive derivatives." Theorists took this stance essentially for two reasons. First, history remembers only those that contribute significantly to the development of a particular point of view. Hence, there are no famous eclectics. Second, the fact that other content areas operate according to their own autonomous principles could impugn the completeness of one's own approach. As a result, various perspectives within psychology have tended to develop the dogmatic schools of psychotherapy to high states of internal consistency. It is not at all clear how one conceptual system might falsify another, or how two systems might be put against one another experimentally. Instead, the proponents of one perspective usually seek to assimilate the variables of other domains to their own perspective, which is then put forward as the best candidate for a truly personalized model for the treatment of its disorders.

In contrast to the modality- or school-oriented perspectives, which appeal to organizing principles that derive from a single system of psychotherapy, we might ask whether there is any theory that honors the nature of psychopathology as the pattern of variables across the entire matrix of the person. Psychopathology is neither exclusively behavioral, exclusively cognitive, nor exclusively interpersonal, but is instead a genuine integration of each of its subsidiary domains. Far from overturning established paradigms, such a broad perspective simply allows a given phenomenon to be treated from several angles, so to speak. Even agnostic therapists, with no strong allegiance to any one point of view, may avail themselves of a kaleidoscope of modalities. By turning the kaleidoscope, by shifting paradigmatic sets, the same phenomenon can be viewed from any of a variety of internally consistent perspectives. Eclecticism becomes a first step toward synthesizing modalities that correspond to the natural configuration of each patient's traits and disorders.

The open-minded therapist is left, however, with several different modality combinations, each with some currency for understanding the patient's pathology, but no real means of bringing these diverse conceptions together in a coherent model of what, exactly, to do. The therapist's plight is understandable, but not acceptable. For example, modality techniques considered fundamental in one perspective may not be so regarded in another. The interpersonal model of Lorna Benjamin and the neurobiological model of Robert Cloninger are both structurally strong approaches to understanding personality and psychopathology. Yet their fundamental constructs are different. Rather than inherit the modality tactics of a particular perspective, then, a theory of psychotherapy as a total system should seek some set of principles that can be

addressed to the patient's whole psyche, thereby capitalizing on the naturally organic system of the person. The alternative is an uncomfortable eclecticism of unassimilated partial views. Perhaps believing that nothing more is possible, most psychotherapists have accepted this state of affairs as an inevitable reality.

Fortunately, modality-bound psychotherapies are increasingly becoming part of the past. In growing numbers, clinicians are identifying themselves, not as psychodynamic or behavioral, but as eclectic or integrative. As noted earlier, eclecticism is an insufficient guide to personalized therapy. As a movement, and not a construct, it cannot prescribe the particular form of those modalities that will remedy the pathologies of persons and their syndromes. Eclecticism is too open with regard to content and too imprecise to achieve focused goals. The intrinsically configurational nature of psychopathology, its multioperationalism, and the interwoven character of clinical domains simply are not as integrated in eclecticism as they need be in treating psychopathology.

Evolution as a Unifying Theoretical Orientation

Before proceeding to an abbreviated outline of assessment and treatment techniques that derive from our specific model, we would like to make a comment in favor of the utility of theory. Kurt Lewin (1936) wrote some 70 years ago that "there is nothing so practical as a good theory." Theory, when properly grounded, ultimately provides more simplicity and clarity than unintegrated and scattered information (Millon & Grossman, 2006a). Unrelated knowledge and techniques, especially those based on surface similarities, are a sign of a primitive science, as has been effectively argued by contemporary philosophers of science (Hempel, 1961; Quine, 1961).

We will present a précis of the general theoretical model we have employed in analyzing personality and psychopathology (Millon, 1969/1985, 1990; Millon, with Davis, 1996a). This is a digression in a way, but it is one that we believe is only proper for our readers to reflect on, especially those who may wish to know more about the underlying logic and grounding on which our diagnostic and therapeutic model adheres.

It is logically impossible for any single perspective on psychotherapy to develop constructs that embrace the person as a whole, that is, a scope and level of synthesis at which the psychopathologic phenomenon itself exists. Perspectives are necessarily analytic, whereas personality is inherently synthetic. An intrinsically synthetic treatment design is exactly what is required to transcend the hodgepodge of eclecticism. Only such a theory can allow for the construction of logically meaningful therapeutic composites and sequences.

Unfortunately, the field does not as yet have an accepted, unifying theory for human behavior. We have generated microtheories that encompass and give coherence to certain facets that compose our psychopathological subject domain. It is toward a larger end that the authors have sought to develop an integrative and unified theory of personality and psychopathology (Millon, 1969/1985, 1981, 1986a, 1990, 1991, 1996b; Millon with Davis, 1996a; Millon & Grossman, 2006a, 2006b) with exemplar integrative concepts for the larger domain of mental disorders. The reader is encouraged

to read Millon with Davis (1996a) for a comprehensive review of the development and derivation of these disorders.

We have gone beyond current conceptual boundaries in our field to explore hypotheses that drew their principles, if not their substance, from other established, adjacent sciences. Not only have such steps generated new conceptual fruits, but they provided a foundation that could undergird and guide our own discipline's explorations. Much of psychopathology, no less psychology as a whole, has remained adrift these past decades, divorced from broader spheres of scientific knowledge, isolated from firmly grounded, if not universal principles, leading us to continue building the patchwork quilt of concepts and data domains that characterize the field. Preoccupied with but a small part of the larger puzzle, or fearing accusations of reductionism, many scientists of the mind have failed to draw on the rich possibilities to be found in other realms of scholarly pursuit. With few exceptions, cohering concepts that would connect psychotherapy and psychopathology to those of its sister sciences have not been developed.

Our effort has been to find theoretical principles for psychopathology that fall outside the field of psychology proper. Otherwise, we would only repeat the error of the past by asserting the importance of some new set of variables heretofore unemphasized, building yet another perspective inside the totality of the person but thereby missing a scientific understanding of our place in the whole of nature. As stated, we went beyond traditional conceptual boundaries in our field to explore hypotheses that drew their inspiration from more established, adjacent sciences.

The fundamental principles we uncovered (Millon, 1990) began with human evolution. Just as each person is composed of a total patterning of variables across all domains of human expression, it is the total organism that survives and reproduces, carrying forth both its adaptive and its maladaptive potentials into subsequent generations. Although lethal mutations sometimes occur, the evolutionary success of organisms with "average expectable genetic material" is dependent on the entire configuration of the organism's characteristics and potentials. Similarly, psychological fitness derives from the relation of the entire configuration of personal characteristics to the environments in which the person functions. Beyond these analogies, the principles of evolution also serve as principles that lie outside personality proper, and thus form a foundation for the integration of the various historical schools that escapes the part-whole fallacy of a dogmatic past. The creation of a taxonomy of personality and psychotherapy based on evolutionary principles is faced with one central question: How can these processes best be segmented so that their relevance to the individual person is placed and highlighted in the foreground?

The evolutionary theory comprises three imperatives (Millon, 1990; Millon & Grossman, 2004), each of which is a necessary aspect of the progression of evolution. First, each organism must survive. Second, it must adapt to its environment. And third, it must reproduce. To each of these imperatives is coupled a polarity that expresses the manifestation of that imperative in the life of the individual organism, thereby giving the theory content and putting metapsychology on a solid basis. To survive, an organism seeks to *maximize pleasure* and *minimize pain,* its **existential aims.** To

adapt, an organism must either *passively conform* to resources and the constraints an environment offers, or *actively reform* the environment to meet its needs and make its opportunities, its **adaptation modes.** And finally, to reproduce, an organism must adopt a classically male and *self-oriented* strategy of producing many offspring with little further investment, or a classically female and *other-oriented* strategy of producing a few or a single offspring, while making a great investment of time and resources, its **replication strategies** (Millon, 1990). These are the fundamental evolutionary concerns of sustainable organisms on earth, and there are none more fundamental.

Polarities, that is, *contrasting* functional directions, representing these three evolutionary processes (pleasure-pain, passive-active, other-self) have been used to construct a theoretically generated classification system of personality styles and clinical disorders (Millon with Davis, 1996a). Such bipolar or dimensional schemes are almost universally present throughout the literatures of mankind, as well as in psychology at large (Millon, 1990). The earliest may be traced to ancient Eastern religions, most notably the Chinese *I Ching* text and the Hebrew Kabala.

In the life of the individual organism, each sequence of evolution is recapitulated and expressed *ontogenetically;* that is, each individual organism moves through developmental stages whose functional goals are related to their respective phases of evolution. Within each stage, every individual acquires character dispositions representing a balance of or predilection toward one of the two polarity inclinations; which inclination emerges as dominant over time results from the inextricable and reciprocal interplay of intraorganismic and extraorganismic factors. For example, during early infancy, the primary organismic function is to "continue to exist." Here, evolution has supplied mechanisms that orient the infant toward life-enhancing environments (pleasure) and away from life-threatening ones (pain).

The expression of traits or dispositions acquired in early stages of development may be transformed as later faculties or dispositions develop (Millon, 1969/1985). Temperament is a classic example. An individual with an active temperament may develop, contingent on contextual factors, into several personality styles, for example, an avoidant or an antisocial, the consequences being partly determined by whether the child has a fearful or a fearless temperament when dealt with a harsh environment. The transformation of earlier temperamental characteristics takes the form of what we have called "personological bifurcations" (Millon, 1990). Thus, if the individual is inclined toward a *passive* orientation and later learns to be self-focused, a narcissistic style ensues. But if the individual possesses an *active* orientation and later learns to be self-focused, an antisocial style may ensue. Thus, early developing dispositions may undergo vicissitudes, whereby their meaning in the context of the whole organism is subsequently re-formed into complex personality configurations.

The evolutionary model that has been presented, as well as its biosocial-learning forerunner (Millon, 1969/1985, 1981, 1986a), has generated several new diagnostic categories, several of which have found their way into the *DSM-III* and *DSM-IV* (Kernberg, 1984). Drawing on the three key components of the polarity framework—pain-pleasure, active-passive, self-other—a series of basic person prototypes and severe

variants were deduced, of which a few have proved to be original derivations in the sense that they had never been formulated as categories in prior psychiatric nosologies (e.g., portraying and coining the avoidant personality designation; Millon, 1969/1985). Progressive research will determine if the network of concepts composing this theory provides an optimal structure for a comprehensive nosology of personality pathology. At the very least, it contributes to the view that formal theory can lead to the deduction of new categories worthy of clinical evaluation and consensual verification.

Before proceeding to elaborate the theory-derived nosology of psychopathology, that is, Axes I and II of the *DSM,* it should be emphasized that the theory provides a basis for deriving the so-called clinical syndromes as well as the personality disorders. To illustrate briefly, the most prevalent mental disorder according to recent epidemiologic studies is that of the anxiety disorders. Without explicating its several variants, a low pain threshold on the pleasure-pain polarity would dispose such individuals to be sensitive to punishments, which, depending on covariant polarity positions, might result in the acquisition of complex syndromal characteristics, such as ease of discouragement, low self-esteem, cautiousness, and social phobias. Similarly, a low pleasure threshold on the same polarity might make such individuals prone to experience joy and satisfaction with great ease; again, depending on covariant polarity positions, such persons might be inclined toward impulsiveness and hedonic pursuits, be intolerant of frustration and delay, and, at the clinical level, give evidence of a susceptibility to manic episodes.

To use musical metaphors again, *DSM-IV*'s Axis I clinical syndromes are composed essentially of a single theme or subject (e.g., anxiety, depression), a salient melodic line that may vary in its rhythm and harmony, changing little except in its timing, cadence, and progression. In contrast, the diversely expressed domains in Axis II seem constructed more in accord with the compositional structure known as the fugue, where there is a dovetailing of two or more melodic lines. Framed in the sonata style, the opening exposition in the fugue begins when an introductory theme is announced (or analogously in psychopathology, a series of clinical symptoms become evident), following which a second and perhaps third and essentially independent set of themes emerge in the form of answers to the first (akin to the unfolding expression of underlying personality traits). As the complexity of the fugue is revealed (we now have identified a full-blown personality disorder), variants of the introductory theme (i.e., the initial symptom picture) develop countersubjects (less observable, inferred traits), which are interwoven with the preceding in accord with well-known harmonic rules (comparably, mechanisms that regulate intrapsychic dynamics). This matrix of entwined melodic lines progresses over time in an episodic fashion, occasionally augmented, at other times diminished. It is sequenced to follow its evolving contrapuntal structure, unfolding a musical quilt, if you will, or better yet, an interlaced tapestry (the development and linkages of several psychological traits). To build this metaphorical elaboration further, not only may personality be viewed much like a fugue, but the melodic lines of its psychological counterpoints are composed of the three evolutionary themes presented earlier (the polarities, that is). Thus, some fugues are rhythmically vigorous and rousing

(high "active"), others kindle a sweet sentimentality (high "other"), still others evoke a somber and anguished mood (high "pain"), and so on. When the counterpoint of the first three polarities is harmonically balanced, we observe a well-functioning or so-called normal person; when deficiencies, imbalances, or conflicts exist among them, we observe one or another variant of the personality disorders.

Personal styles we have termed *deficient* lack the capacity to experience or to enact certain aspects of the three polarities (e.g., the schizoid style has a faulty substrate for both pleasure and pain); those spoken of as *imbalanced* lean strongly toward one or another extreme of a polarity (e.g., the dependent style is oriented almost exclusively to receiving the support and nurturance of others); and those we judge in conflict struggle with ambivalences toward opposing ends of a bipolarity (e.g., the negativistic style vacillates between adhering to the expectancies of others and enacting what is wished for oneself).

Evolutionary theory is not undertaken for purposes of understanding alone. Its ultimate aim is to lead to intelligent remedial action.

Personality Styles and Disorders: Focusing on the Whole Person

As stated earlier, not all patients with the same diagnosis should be viewed as possessing the same problem. Platitudinous though this statement may be, care must be taken not to force patients into the procrustean beds of our theoretical models and nosological entities. Whether or not they are derived from mathematical analyses, clinical observations, or a systematic theory, all taxonomies are essentially composed of prototypal classes. Clinical categories must be conceived as flexible and dimensionally quantitative, permitting the full and distinctive configuration of characteristics of patients to be displayed (Millon & Grossman, 2006b). The multiaxial schema of *DSM-IV* is a step in the right direction in that it encourages multidimensional considerations as well as multidiagnoses that approximate the natural heterogeneity of patients. It is our view, however, that the atheoretical orientation of the *DSM-IV* does a disservice to assessment and psychotherapy because it bypasses highly informative interpretations that can be generated by a comprehensive theory, be it cognitive, psychoanalytic, or evolutionary.

Applying the Polarities of the Evolutionary Model

As will be elaborated later, the *DSM* personality prototypes simply list characteristics that have been found to accompany a particular disorder with some regularity and specificity. This approach is necessary, but insufficient. The *DSM* does put forward several domains in which personality is expressed, notably, cognition, affectivity, interpersonal functioning, and impulse control. However, these psychological domains are neither comprehensive nor are they applied comparably to all personality disorders.

Both the nature of the person as a synthetic construct and the laws of evolution require that the several domains of personality be organized in a logical fashion. The antagonism that exists among the competing domain approaches (cognitive, biological) in our discipline is largely an illusion wrought by human habits. No clinical trait domain should be seen as an autonomous entity. Rather, both the structure and the content of personality are mediated by the evolutionary imperatives of survival, adaptation, and reproductive success. It is always the entire organism as a whole that survives and evolves. The domains of the person are synthesized as a coherent unity. What we call the *functional* domains relate the organism to the external world; other domains serve as the *structural* substrates for such functioning. The distinction between function and structure parallels the distinction between the biological fields of physiology and anatomy. Anatomy investigates embedded and essentially permanent structures, which serve, for example, as substrates for mood and memory, whereas physiology examines functions that regulate internal dynamics and external transactions.

These functional and structural domains have parallels in numerous historical traditions as well as current major approaches to our field (Millon, 2004). This should not be surprising, given that progress in the softer sciences has proceeded slowly through the elucidation of previously neglected yet relevant variables. For example, the recent rise of the cognitive and the interpersonal perspectives were all but inevitable. The particulars of history influenced the timing at which these evolutions occurred but could not prevent their emergence. Thus, among the functional domains we have the Expressive Behavior domain representing the modern legacy of Thorndike, Skinner, and Hull, for example, while the Interpersonal Conduct domain represents the interpersonal tradition originating with Sullivan and expressed today by Kiesler (1986) and L. S. Benjamin (1993), among others. The Cognitive Style domain obviously represents the cognitive tradition, of which Beck (1976) is the most notable modern exponent, while the Regulatory Mechanisms and Object Representations domains parallel the ideas of defense mechanisms and object relations of the psychodynamic school (Millon, 2004). All of these are legitimate approaches to personality and through their very existence provide empirical support for the position advanced earlier: that person pathologies are best thought of as disorders of the entire matrix of the person. The alternative is a reduction of this complex matrix to one perspective, be it behavioral, cognitive, or psychodynamic—in other words, to substitute a part for the whole.

Three treatment themes may usefully be made to illustrate the combinatorial variations among the three polarities.

At the simplest level of analysis a number of personologic consequences of a single polar extreme are briefly noted. A high standing on the pain pole—a position typically associated with a disposition to experience anxiety—will be used for this purpose. The upshot of this singular sensitivity will take different forms depending on a variety of factors that lead to the learning of diverse styles of anxiety-neutralizing. For example, *avoidants* learn to deal with their pervasively experienced anxiety sensitivity by removing themselves across the board, that is, actively withdrawing from most relationships

unless strong assurances of acceptance are given. The *compulsive,* often equally prone to experience anxiety, has learned that there are sanctioned but limited spheres of acceptable conduct; the compulsive reduces anxiety by restricting activities to those that are permitted by more powerful and potentially rejecting others, as well as to adhere carefully to rules so that unacceptable boundaries will not be transgressed. And the anxiety-prone *paranoid* has learned to neutralize pain by constructing a semidelusional pseudocommunity (Cameron, 1963), one in which environmental realities are transformed to make them more tolerable and less threatening, albeit not very successfully. In sum, a high standing at the pain pole leads not to one, but to diverse personality outcomes.

Another of the polar extremes illustrates the diversity of forms that personal styles may take as a function of covariant polarity positions, in this case, a shared position on the "passivity" pole. Six primary personality disorders demonstrate the passive style, but their passivity derives from and is expressed in appreciably different ways that reflect disparate polarity combinations. *Schizoids,* for example, are passive owing to their relative incapacity to experience pleasure and pain; without the rewards these emotional valences normally activate, they will be devoid of the drive to acquire rewards, leading them to become rather indifferent and passive observers. *Melancholic* personalities have given up on life and passively accept their misfortunes. Unwilling to make efforts to overcome their "fate," they exhibit little initiative to change their circumstances. *Dependents* typically are average on the pleasure and pain polarity, yet they are usually no less passive than schizoids or depressives. Strongly oriented to others, they are notably weak with regard to self. Passivity for them stems from deficits in self-confidence and self-competence, leading to deficits in initiative and autonomous skills as well as a tendency to wait passively while others assume leadership and guide them. Passivity among *compulsives* stems from their fear of acting independently owing to intrapsychic resolutions they have made to quell hidden thoughts and emotions generated by their intense self-other ambivalence. Dreading the possibility of making mistakes or engaging in disapproved behaviors, they become indecisive, immobilized, restrained, and passive. High on pain and low on both pleasure and self, *masochistic* personalities operate on the assumption that they dare not expect nor do they deserve to have life go their way; giving up any efforts to achieve a life that accords with their "true" desires, they passively submit to others' wishes, acquiescently accepting their fate. Finally, *narcissists,* especially high on self and low on others, benignly assume that good things will come their way with little or no effort on their part; this passive exploitation of others is a consequence of the unexplored confidence underlying their self-centered presumptions.

To turn to slightly more complex cases, there are individuals with appreciably different personality patterns who are often characterized by highly similar clinical features. To illustrate: To be correctly judged as "humorless and emotionally restricted" may be the result of diverse polarity combinations. *Schizoids,* as noted previously, are typically at the low end of both dimensions of the pleasure-pain bipolarity, experiencing little

joy, sadness, or anger; they are quite humorless and though not restricted emotionally, do lack emotional expressiveness and spontaneity. By contrast, *avoidants* are notably high at the pain polar extreme; whatever their other traits may be, they are disposed to choose neither interpersonal humor nor emotional openness in their social interactions. Finally, the self-other–conflicted *compulsive* has learned to deny self-expression as a means of assuring the approval of others. Rarely will the compulsive let down his or her guard, lest any true oppositional feelings be betrayed; a compulsive rarely is relaxed sufficiently to engage in easy humor or willing to expose any contained emotions. All three personalities are humorless and emotionally restricted, but for different reasons and as a consequence of rather different polarity combinations.

The seeming theoretic fertility of the evolutionary polarities secures but a first step toward a systematic treatment framework. Convincing professionals of the validity of the schema requires detailed explications, on the one hand, and unequivocal evidence of utility, on the other. We must not only clarify what is meant by each term of the polarities—for example, identifying or illustrating their empirical referents—but also specify ways they may combine and manifest themselves clinically. It is toward those ends that the clinical chapters of this and other books of this personalized therapy series are addressed.

As may be inferred from the foregoing, it is both feasible and productive to employ the key dimensions of the bipolar evolutionary model to make the clinical features of the basic styles of personality functioning more explicit, from the actively pain-sensitive avoidant to the passively self-centered narcissist, and from the actively other-oriented histrionic to the self-other–conflicted negativistic (passive-aggressive; see Figure 1.1). The bias toward adaptive modes that is inherent in an evolutionary thesis does enable the identification of alternative mixtures in which these more pathological syndromes are expressed—hence, the clinical presence of frequent comorbidity, such as histrionic borderlines, sadistic paranoids, avoidant schizotypals, and passive-aggressive borderlines.

Responses to the preceding issues point to the inadequacy of any approach that links taxonomic criteria to intervention without theoretical guidance, as well as one that encompasses the functional-structural nature of the person (to be elaborated in the forthcoming sections on domain characteristics). The argument is merely that diagnosis should constrain and guide therapy in a manner consonant with accepted standards of the theoretically derived prototypal model. The scope of the interventions that might be considered appropriate and the form of their application has been left unattended. Any set of interventions or techniques might be applied singly or in combination, without regard to the diagnostic complexity of the treated disorder. In the actual practice of therapy, techniques within a particular pathological data level (i.e., psychodynamic techniques, behavioral techniques, and so on) are, in fact, often applied conjointly. Thus, systematic desensitization might be followed by in vivo exposure, or a patient might keep a diary of his or her thoughts while at the same time reframing those thoughts in accordance with the therapist's directions when they

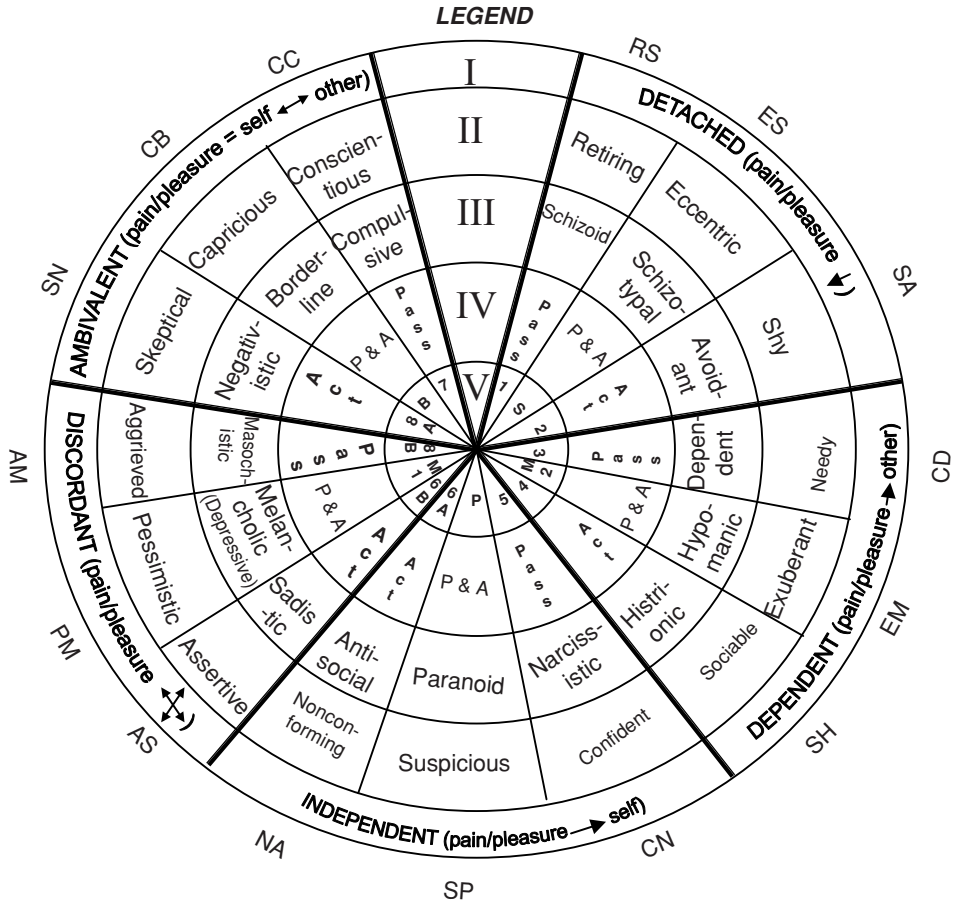

FIGURE 1.1 Personality spectra circulargram I: Normal and abnormal personality patterns. Evolutionary foundations of the normal and abnormal extremes of each personality prototype of the 15 spectra. I: Evolutionary Orientation; II: Normal Prototype; III: Abnormal Prototype; IV: Adaptation Style; V: MCMI-III-E Scale number/letter.

occur. In these formulations, however, there is no strong a priori reason why any two therapies or techniques should be combined at all. As noted previously, when techniques from different modalities are applied together successfully, it is because the combination mirrors the composition of the individual case, not because it derives its logic on the basis of a theory or the syndrome.

Personality Spectra and Domains

The text, figures, and tables in this chapter will provide the reader with a brief synopsis of the personality-based evolutionary model; other sources should be pursued for a

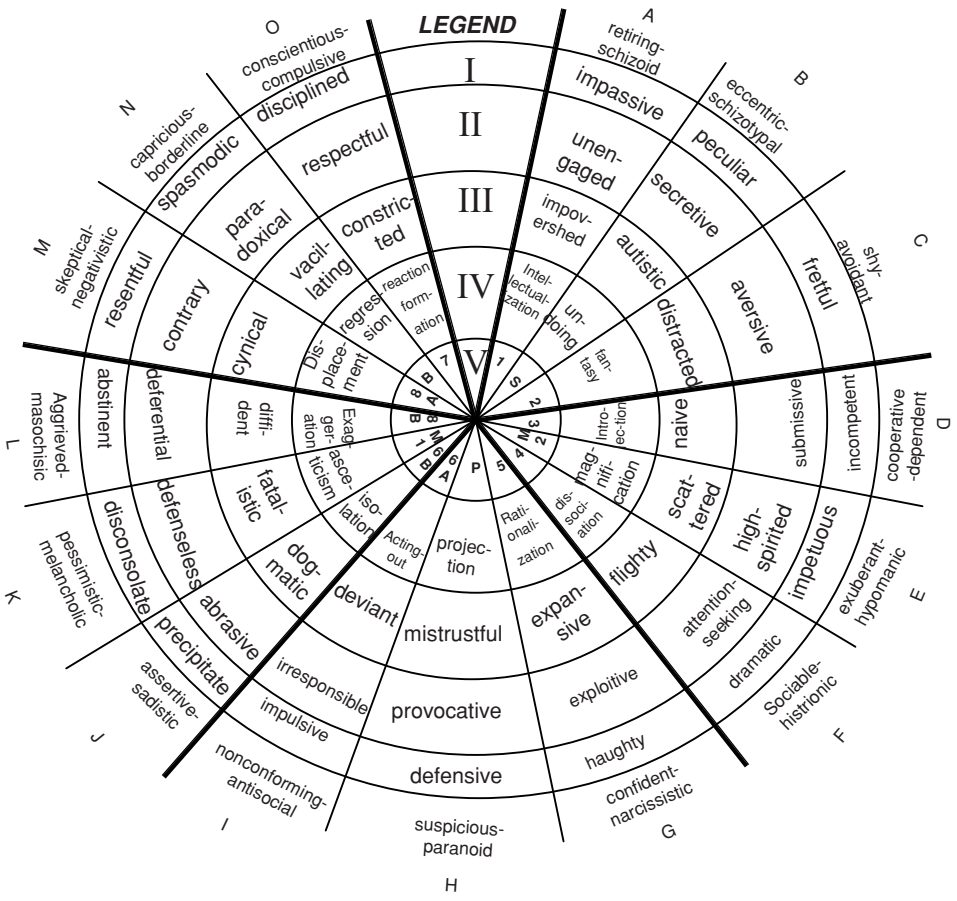

FIGURE 1.2 Personality circulargram IIA: Functional personologic domains. I: Expressive Behavior; II: Interpersonal Conduct; III: Cognitive Style/Content; IV: Intrapsychic Mechanisms; V: MCMI-III Scale.

more extensive elaboration of these ideas (Millon, Bloom, & Grossman, in press; Millon & Davis, 1996; Millon & Grossman, in press).

Three figures, 1.1, 1.2, and 1.3, present circumplex representations of the overall theoretically derived personality spectra of normal and abnormal patterns and their associated clinical domains. Figure 1.1, the Personality Spectra Circulargram, portrays the 15 prototypal variants derived from the theory. Legend I of Figure 1.1 relates to the prototype's primary evolutionary foundation (e.g., the retiring/schizoid reflects a detached pattern that stems from deficiencies in the pain-pleasure polarity). Figure 1.2 represents the four *functional* domains for each of the 15 personality prototype patterns. Legend II of Figure 1.2, for example, relates to the prototype's characteristic interpersonal conduct (e.g., the retiring/schizoid's conduct is noted as unengaged).

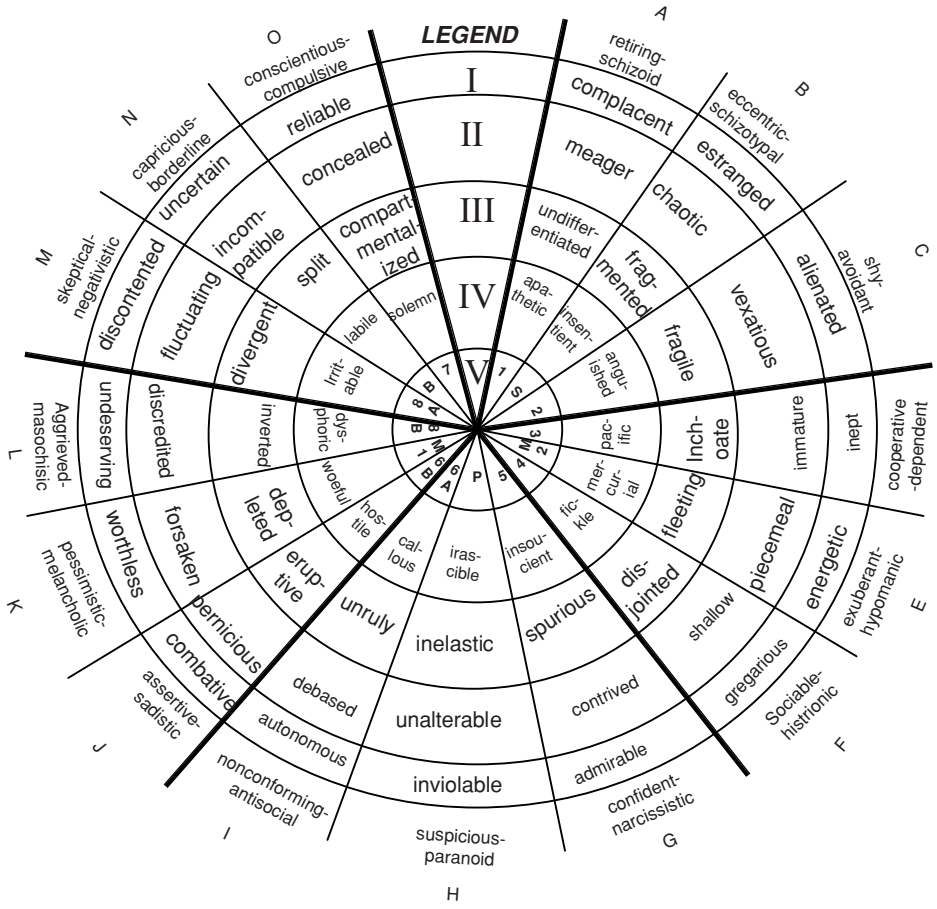

FIGURE 1.3 Personality circulargram IIB: Structural personologic domains. I: Self-Image; II: Intrapsychic Content; III: Intrapsychic Structure; IV: Mood-Affect; V: MCMI-III Scale.

Figure 1.3 portrays the four *structural* domains for all of the 15 personality prototypes. Legend IV of Figure 1.3, to illustrate, concerns the prototypal fundamental mood/affect (e.g., the retiring/schizoid's typical mood is recorded as apathetic).

Scores on these functional and structural domains, as calculated by MCMI-III analyses and/or obtained on the Millon-Grossman Personality Domain Checklist (MG-PDC), to be described shortly, serve as the basis for identifying, selecting, and coordinating the major foci and techniques of therapeutic action. Thus, high ratings on the pessimistic/melancholic interpersonal and mood/affect domains may identify the more problematic realms of a patient's psychological makeup. It also suggests the use of a combination of two therapeutic techniques: interpersonal methods (e.g., L. S.

Benjamin's approach, 2003) and pharmacologic medications (e.g., daily regimen of Prozac).

Complex Syndromes: Focusing on Symptom Clusters

A historic and still frequently voiced complaint about diagnosis, based or not on an official classification system, is its inutility for therapeutic purposes. Most therapists, whatever their orientation or mode of treatment, pay minimal attention to the possibility that diagnosis can inform the philosophy and technique they employ. It matters little what the syndrome or disorder may be, a family therapist is likely to select and employ a variant of family therapy, a cognitively oriented therapist will find that a cognitive approach will probably work best, and so on, including integrative therapists who are beginning to become a school and join this unfortunate trend of asserting the "truth" that their approach is the most efficacious.

A clinical study that attempted to unravel all of the elements of a patient's past and present would be an exhausting task indeed. To make the job less onerous, clinicians must narrow their attention to certain features of a patient's past history and behavior that may prove illuminating or significant. This reduction process requires that clinicians make a series of discriminations and decisions regarding the data they observe. They must find a constellation of core characteristics (e.g., cognitive style, interpersonal behavior) that capture the essential personal pattern of the patient and will serve as a framework to guide assessment and treatment.

Several assumptions are made by diagnosticians in narrowing their focus to this limited configuration of symptom domains. They assume that a patient possesses a core of interrelated behaviors, feelings, and attitudes that are central to his or her manifest pathology, that these characteristics are found in common among distinctive and identifiable groups of patients, and that prior knowledge regarding the features of these distinctive patient groups, hereby termed *complex clinical syndromes,* will facilitate therapists' clinical responsibilities and functions.

What support is there for these assumptions?

There are both theoretical and empirical justifications for the belief that people display a composite of linked characteristics, and that there is an intrinsic unity among these traits over time. Careful study of individuals with complex clinical syndromes will reveal a congruency among behaviors, cognitive reports, intrapsychic functioning, and biophysical disposition. This coherence or unity of psychic functioning is a valid phenomenon; that it is not merely imposed upon clinical data as a function of theoretical bias is evident by the fact that similar patterns of complex syndromes are observed by diagnosticians of differing theoretical persuasions. Moreover, these findings follow logically from the fact that people possess relatively enduring biophysical dispositions that give a consistent coloration to their experiences, and that the actual range of experiences to which they have been exposed throughout their lives is highly

limited and repetitive. It should not be surprising, therefore, that individuals develop a complex pattern of distinguishing, prepotent and deeply ingrained behaviors, attitudes, and needs. Once several elements of these complex syndromes are identified, the clinician should have a fruitful basis for inferring the likely presence of other, unobserved, but frequently correlated features of the patient's life history and current functioning.

If we accept the assumption that people display covariant symptoms, we are led next to the question of whether certain patients evidence a commonality in the pattern of characteristics they display. The notion of complex clinical syndromes rests on the assumption that there are a limited number of symptom patterns that can be used profitably to distinguish certain groups of patients. The hope is that the diagnostic placement of a patient within one of these complex syndromal groups will clue the diagnostician to a wider pattern of the patient's difficulty, thereby simplifying the clinical task immeasurably. Thus, once diagnosticians identify clusters of clinical characteristics in a particular patient, they will be able to utilize the knowledge they have learned about other patients evidencing that syndrome and apply that knowledge to the present patient.

The fact that patients can profitably be categorized into complex clinical syndromes does not negate the fact that patients so categorized will display differences in the presence and constellation of their characteristics. The philosopher Grunbaum (1952, pp. 665–676) illustrates this thesis in the following:

> Every individual is unique by virtue of being a distinctive assemblage of characteristics not precisely duplicated in any other individual. Nevertheless, it is quite conceivable that the following . . . might hold: If a male child having specifiable characteristics is subjected to maternal hostility and has a strong paternal attachment at a certain stage of his development, he will develop paranoia during adult life. If this . . . holds, then children who are subjected to the stipulated conditions in fact become paranoiacs, however much they may have differed in other respects in childhood and whatever their other differences may be once they are already insane.

There should be little concern about the fact that certain "unique" characteristics of each patient will be lost when he or she is grouped in a complex syndrome; differences among members of the same syndrome will exist, of course. The question that must be raised is *not* whether the syndrome is entirely homogeneous, as no complex category meets this criterion, but whether placement in the category impedes or facilitates a variety of clinically relevant objectives. Thus, if this grouping of key characteristics simplifies the task of clinical analysis by alerting diagnosticians to features of the patient's past history and present functioning that they have not yet observed, or if it enables clinicians to communicate effectively about their patients or guides their selection of beneficial therapeutic plans or assists researchers in the design of experiments, then the existence of these syndromal categories has served many useful purposes. No single

classification schema can serve all of the purposes for which clinical categories can be formed; all we can ask is that it facilitate certain relevant functions.

As noted previously, the diagnostic criteria of the *DSM-IV* have *not* been explicitly constructed to facilitate treatment, no less personalized psychotherapy. Criteria should do more than classify persons into categories, a rather minimalistic function. Instead, diagnostic criteria should encourage an integrative understanding of the patient across all those psychic domains in which the person's mental impairments are expressed. The *DSM-IV* criteria, disproportionately weighted in some symptom domains and nonexistent in others, cannot perform this function. At this point in time, personalized psychotherapy requires that the official diagnostic criteria be supplemented by clinical judgment. Obviously, effective synergistic therapy requires a detailed assessment of all those symptom domains that can exist as constraints on system functioning. Because the *DSM-IV* therapist simply would not be cognizant of such abnormalities, techniques appropriate to those domains would not be used either combinatorially or in series. Using *DSM-IV* criteria alone as a guide to the substantive characteristics of personality and syndromes would effectively leave some systems constraints completely unobserved, free to operate insidiously in the background to perpetuate the pathological tenacity of the system as a whole. Consequently, a *DSM-IV* -based therapy is not necessarily a personalized therapy.

We next review some of the distinctions between *complex* clinical syndromes and *simple* clinical reactions. In essence, the distinction is traceable to the interweaving of intrapsychic, cognitive, and interpersonal elements in the complex syndrome. The residuals of the past intrude on the individual's present perceptions and behaviors, often giving rise to seemingly irrational symptoms. Both complex clinical syndromes and simple reactions are classed among the *DSM-IV* Axis I disorders, an unfortunate decision that overlooks important distinctions. It is only in the complex syndromes that we see the compounding of pervasive interpersonal relations, unconscious emotions, cognitive assumptions, self-images, and so on.

Differentiating Simple Reactions from Complex Syndromes

Simple clinical reactions, complex clinical syndromes, and personality styles and disorders lie on a continuum such that the simple clinical reaction is essentially a straightforward singular symptom, unaffected by other clinical domains of which the-person-as-a-whole is composed (Millon, 1969/1985). At the other extreme are personality styles and disorders which comprise an interrelated mix of cognitive attitudes, interpersonal styles, and biological temperaments and intrapsychic processes. Complex clinical syndromes lie in between, manifestly akin to simple syndromes but interwoven and mediated by pervasive personality traits and embedded vulnerabilities.

Clinical signs in *personality disorders* reflect the operation of a pattern of deeply embedded and pervasive characteristics of functioning, that is, a system of traits that systematically "support" one another and color and manifest themselves automatically

in all facets of the individual's everyday life. By contrast, *simple clinical reactions* are relatively direct responses that derive from specific neurochemical dysfunctions or are prompted by rather distinctive stimulus experiences. Simple reactions operate somewhat independently of the patient's overall personality pattern; their form and content are determined largely by the character of a biologic vulnerability or the specifics of an external precipitant; that is, they are not contaminated by the intrusion of other psychic domains or forces. Simple clinical reactions are best understood *not* as a function of the intricate convolutions among intrapsychic mechanisms, interpersonal behaviors, cognitive misperceptions, and the like, but as simple and straightforward responses to an endogenous liability or to adverse and circumscribed stimulus conditions. To paraphrase Eysenck (1959): There are no obscure "causes" that "underlie" simple clinical reactions, merely the reaction itself; modify the reaction, or the conditions that precipitate it, and you have eliminated all there is to the pathology.

The overt clinical features of the simple clinical reactions and the *complex clinical syndromes* are often indistinguishable; moreover, both are prompted *in part* by external precipitants.

How are they different?

Complex clinical syndromes are rooted in part to pervasive personality vulnerabilities and coping styles, whereas simple clinical reactions are not. Complex syndromes usually arise when the patient's established personality equilibrium has been upset or threatened. At that point, numerous domains of expression come into play in the patient's effort to reestablish a modicum of stability. Unfortunately, as often occurs in medical diseases, the reparative process itself becomes highly problematic, creating additional difficulties. Hence, therapy must attend not only to the primary clinical domain that has begun the process, but to many of the secondary domains of expression. Complex clinical syndromes often arise in response to what objectively is often an insignificant or innocuous event; despite the trivial and specific character of the precipitant, the patient exhibits a mix of complicated responses that have minimal relationship to how normal persons respond in these circumstances. Thus, complex clinical syndromes often do not "make sense" in terms of actual present realities; they signify an unusual vulnerability and an overreaction on the part of the patient, that is, a tendency for objectively neutral stimuli to touch off and activate cognitive misperceptions, unconscious memories, and pathological interpersonal responses. Complex syndromes usually signify the activation of several traits that make up the varied facets of a personality style or disorder. They are seen in individuals who are encumbered with the residues of deeply embedded past experiences or adverse life events that have led to the acquisition of problematic cognitive beliefs and behavioral habits.

As suggested, unconscious memories, self-attitudes, and interpersonal dispositions intervene in the expression of complex syndromes, complicating the connection between present stimuli and the patient's response to them. As we see it, intrusions of this nature do not occur in simple clinical reactions. In the latter, the patient's

vulnerabilities are neither deep nor widespread, but restricted to a limited class of biological vulnerabilities or environmental conditions. These pathological responses do not pass through a chain of complicated and circuitous intrapsychic and cognitive transformations before they emerge in manifest form. Thus, in addition to the restricted number of precipitants that give rise to them, simple reactions are distinguished from complex syndromes in the more or less direct route through which they are channeled and expressed clinically.

In complex syndromes, a precipitating stimulus will stir up a wide array of intervening thoughts and emotions which then take over as the determinant of the response; reality stimuli serve merely as catalysts that set into motion a complex chain of intermediary processes that transform what might otherwise have been a fairly simple and straightforward response. Because of the contaminating intrusion of these transformations the complex response acquires an irrational and often symbolic quality. For example, in complex phobias the object that is feared often comes to represent something else; a phobia of elevators might come to symbolize a more generalized and unconscious anxiety about being closed in and trapped by others.

Because of the frequent pervasiveness of complex syndromal vulnerabilities, thoughts and behaviors become entangled in a wide variety of dissimilar stimulus situations, for example, the feeling of being trapped may give rise to a phobia not only of elevators but also of rooms in which the doors are shut, of riding in cars in which the windows are closed, of tight clothes. Moreover, these complicated processes vary in their form and degree of intrusion; for example, a phobic patient may feel well on certain days and agree to the closing of room doors; on other days, however, all doors and windows must be wide open. Thus, the responses of complex syndromes not only are elicited by a wide variety of stimulus conditions, but these diverse responses wax and wane in their relative salience.

All this fluidity and variability in complex clinical syndromes contrast with the relative directness and uniformity of responses found in simple clinical reactions. Uninfluenced by the intricate and circuitous transformations of other facets of the person's psyche, simple reactions tend to be consistent and predictable. They are manifested in essentially the same way each time the endogenous vulnerability or troublesome stimulus to which they have been attached occurs. Moreover, they are rarely exhibited at other times or in response to events that are dissimilar to the stimulus to which they were originally attached. In short, simple clinical reactions are ingrained, but they are *isolated responses* to specific inner or outer stimulus events. They tend not to vary or be influenced by the patient's general personal makeup. They are relatively compartmentalized stimulus-response reactions that are isolated in large measure from the patient's larger and characteristic pattern of functioning. They may be narrowly focused behaviors, displaying themselves only in response to specific types of stimulus events. To use an analogy, we might speak of complex syndromes emerging from several interwoven domains of personality structure and function; they are both body and basic design of a fabric, whereas the simple reaction may be seen as an embroidered decoration that

has been sewn onto it. One may remove (extinguish) the embroidery with relative ease (as conditioning therapists have done in treating the simple clinical reactions) without involving or altering the body of the cloth (personality). Simple clinical reactions, then, do not permeate and intrude on the many facets of the individual's transactions with his or her world, as do the trait covariants of complex disorders; rather, they are stimulus-specific responses to either a circumscribed inner or outer class of stimuli.

Despite the preceding, there are many similarities between simple reactions and complex syndromes. For example, anxiety can be either simple or complex. Both are characterized by feelings of tension and by a rapid increase in sympathetic nervous system reactivity (perspiration, muscular contraction, and rapid heartbeat). They differ in that the origins of complex anxiety disorders are difficult to decode and are often unanchored and free-floating. In contrast, simple anxiety reactions usually are connected to a readily identifiable stimulus.

As another illustration, complex phobic syndromes and simple phobic reactions are alike in that both may be precipitated by a tangible external stimulus, leading taxonomists to question whether any difference exists between them. As we conceive it, the difference is a matter of the degree and complexity with which other clinical domains contribute to the pathological response. Complex phobias, as we define them, signify that intricate and highly convoluted cognitive and emotional processes have played a determinant role in "selecting" a provocative stimulus that subjectively represents, but is objectively different from, that which may actually be feared; for example, a phobia for open places may symbolize a more generalized fear of assuming independence of others. In contrast, what we have termed a simple phobic reaction is a direct, nonsymbolic response to the actual stimulus the patient has learned to fear, for example, a fear of Asian persons that is traceable to distressing encounters in childhood with a Chinese teacher. Of course, some measure of generalization occurs in simple reactions, but the individual tends to make the simple response only to objects or events that are essentially similar or closely allied with the original fear stimulus; for example, learning to fear a cat in early life may be generalized into a fear of dogs because these animals are barely discriminable in the eyes of the very young. At most, then, the simple phobic reaction may reflect an uncomplicated generalization. Although often appearing irrational to the unknowing outsider, they can be traced directly to these reality-based and well-circumscribed experiences.

Complex clinical syndromes tend to occur in persons whose histories are replete with innumerable instances of adverse experience. Given their repeated exposure to mismanagement and faulty learning experiences, these individuals have built up an obscure psychic labyrinth, a residue of complex, tangentially related, but highly interwoven cognitions, emotions, and interpersonal behaviors that are easily reactivated under the pressure of new stressors. Because these intervening processes are stirred up under new stressful conditions, no simple and direct line can be traced between the overt response and its associated precipitant. The final outcome, as in complex phobias, often appears to be symbolic rather than simply generalized because the

associative route is highly circuitous, involving both the residuals of the past and numerous distortion mechanisms. Complex syndromes are formed by the crystallization of diffusely anchored and transformed past learnings acquired in response to a wide and diverse range of faulty experiences; this pervasively adverse background and the rather circuitous sequence of distortions are what are activated among pathological persons. Because "normals" are not likely to have had such pervasively adverse experiences, they have had little reason to develop a complex of behavioral styles and defensive maneuvers to avoid the reactivation of distressing memories and emotions; as a result, what we observe in them are relatively clean, that is, simple and direct.

It should be noted that the continuum we have drawn between simple and complex syndromes cannot be drawn with ease in describing characteristics of the first years of life. During this early period, learnings have not crystallized into ingrained, pervasive, stable, and consistent styles of life. In many respects, childhood personality is a loose cluster of scattered habits and beliefs learned in response to a wide variety of odds-and-ends experiences. Over time, however, as certain of the conditions that gave rise to these habits and beliefs are repeated and attached to an increasing variety of stimuli, and as the child's own self-perpetuating processes accentuate and spread the range of these events further, some of these simple reactions become more dominant than others, until they may take shape as pervasive and ingrained personality traits. Thus, early simple reactions may become the precursors of later complex syndromes and personality patterns; it is a continuous developmental process.

Let us briefly recapitulate and extend several points.

Coping refers to processes of instrumental activity that are learned as a function of experience. These processes enable individuals to maintain an optimum level of psychological integration by increasing the number of life-enhancing satisfactions they achieve (e.g., attention, comfort, pleasure, and status) and avoiding as many life-endangering experiences as they can (e.g., punishment, frustration, rejection, and anxiety).

Psychic pathologies utilize coping behaviors to achieve several goals, such as counteracting external precipitants that threaten to upset their equilibrium and tenuous controls; blocking reactivated anxieties and impulses from intruding into conscious awareness, thereby avoiding potentially upsetting social condemnation; discharging tensions engendered by external stressors and their intrapsychic residuals; and soliciting attention, sympathy, and nurture from others.

It is the synthesis of goals such as these that also distinguishes simple reactions from complex clinical syndromes. Diluting tensions while at the same time blocking awareness of their true source, avoiding social rebuke, and evoking social approval and support in their stead, is characteristic of the complex syndromes, a task of no mean proportions. It requires the masking and transformation of one's true thoughts and feelings by the intricate workings of several psychic mechanisms. The resulting complex syndrome symptom represents the interplay and final outcome of numerous psychic and interpersonal maneuvers. Not only have the patient's anxieties and impulses been disguised sufficiently to be kept from conscious awareness, but they also managed to

solicit interpersonal acceptance as well as achieve a measure of cognitive resolution and tension discharge.

Alexander (1930) reports a classic case of phobia in which the patient's symptom achieved her goals through a complex psychic resolution:

> A young woman dreaded going into the street alone, the thought of which made her feel faint and extremely anxious. Upon clinical investigation it became clear that a forbidden and unconscious sexual impulse was associated with her phobia; each time she would go out her impulse would be stimulated by the thought that a man might "pick her up" and seduce her. The thought both excited her and caused her intense anxiety. To avoid the true character of her forbidden desire and the tension it provoked she displaced her tension to an associated and more generalized activity, that of going into the street; thus, her phobia. However, she was able to venture out quite undisturbed if accompanied by a relative. In this way she could engage in fleeting sexual fantasies as she passed attractive men, without the fear that she might be carried away and shamed by her forbidden impulse. Her symptom was extremely efficient; not only did it enable her to maintain psychological cohesion by controlling her impulse, blocking her awareness of its true source and keeping her behavior within acceptable social boundaries, but, at the same time, it solicited the assistance of others who enabled her to find some albeit skimpy means of gaining both tension and impulse release.

The case just described brings us to another aspect of complex clinical syndromes: the tendency for symptoms to achieve what are known as secondary gains. According to traditional theory, the primary function of clinical syndromes is the avoidance, control, and partial discharge of anxiety, or, as we would be inclined to call it, the elimination of a strong upsurge of negative feelings stemming from unconscious sources. But, in addition, the psychic maneuver may produce certain positive consequences; that is, as a result of his of her clinical syndrome, the patient may obtain secondary advantages or rewards. In the case just described, for example, the woman's phobic symptom achieved a positive result above and beyond the reduction of the negatively toned anxiety; in the role of a sick and disabled person, she solicited attention, sympathy, and help from others and was freed of the responsibility of carrying out many of the duties expected of a healthy adult. In this fashion her symptom not only controlled and partially vented her anxieties, but enabled her to gratify a more basic dependency need.

The distinction between primary gains (anxiety neutralization) and secondary gains (positive rewards) may be sharply drawn at the conceptual level but is difficult to make when analyzing actual cases because the two processes intermesh closely in reality. However, the conceptual distinction may be extremely important. As we view it, secondary gains play no part in the formation of simple clinical reactions. Here, patients are prompted to develop their symptom not as a means of gaining secondary or positive rewards, but as a means of avoiding, controlling, or discharging anxiety.

This sharp distinction between primary and secondary gains seems rather arbitrary and narrow. Although it is true that anxiety neutralization is centrally involved in

complex syndromes, this, in itself, could not account for the variety of symptoms that patients display (e.g., somatoform, obsessive-compulsive). We may ask: Why are certain forms of interpersonal conduct and psychic mechanisms employed by some patients and different ones by others, and why do certain symptoms rather than others emerge? If the sole purpose of syndrome formation were anxiety abatement, then any set of mechanisms could fulfill that job, giving rise to any number and variety of different syndromes.

This, however, is not the case. It seems that most complex syndrome maneuvers both neutralize anxiety (primary gain) and, at the same time, achieve certain positive advantages (secondary gain). We believe that complex clinical syndromes reflect the joint operation of both primary and secondary gain strategies (neither of which, we should note, is consciously planned). Furthermore, we propose that complex clinical syndromes, albeit different overtly, have a common and covert secondary gain characteristic that distinguishes them from simple reactions; that is, their symptoms (phobias, conversions) serve to neutralize tensions, and do so without provoking social condemnation, eliciting, in its stead, support, sympathy, and nurture.

Personality Domain Traits Underlying Complex Syndromes

The prognostic course of simple reactions is relatively predictable and uncomplicated, assuming that the diagnosis is correct. It can safely be expected that the patient will regain normal composure and functioning shortly following the removal of the stressful inner or outer precipitant.

As noted earlier, complex clinical syndromes display themselves in such ways as both to avoid social derogation and to elicit support and sympathy from others. In Alexander's (1930) example, a phobic patient manipulated members of her family into accompanying her in street outings, where she gained the illicit pleasures of sexual titillation; through her unfortunate disablement, she fulfilled her dependency needs, exerted interpersonal control over the lives of others, and achieved partial impulse gratification without social condemnation. Let us look at two other examples. A depressed woman not only may be relieved of family responsibilities, but through her subtly angry symptom makes others feel guilty and limits their freedom while still gaining their concern, and yet does not provoke retribution. A hypochondriacal woman experiences diverse somatic ailments that preclude sexual activity; she not only gains her husband's compassion and understanding, but does so without his recognizing that her behavior is a subtle form of punishing him; she is so successful in her maneuver that her frustration of his sexual desires is viewed, not as an irritation or a sign of selfishness, but as an unfortunate consequence of her physical illness. Her plight evokes more sympathy for her than for her husband.

Why do the symptoms of complex clinical syndromes take this particular, devious route? Why are their anxieties or otherwise socially unacceptable impulses masked and transformed so as to appear not only socially palatable, but evocative of support and

sympathy? To answer this question we must examine which of the various personality styles and disorders tend to exhibit these clinical syndromes. When we do, we discover that they are found primarily among avoidants, depressives, dependents, histrionics, compulsives, negativists, masochists, and borderlines. More will be said when we discuss these syndromes and personalities in later chapters and other books in this series.

What rationale can be provided for the covariation of certain personality patterns and complex clinical syndromes?

We previously stated that a clearer understanding of complex clinical syndromes is achieved by a study of the context of a patient's personality. Complex syndromes are largely an outgrowth of deeply rooted habits, vulnerabilities, and coping strategies. What events a person perceives as threatening or rewarding and what behaviors and mechanisms he or she employs in response to them depend on the history to which he or she was exposed. If we wish to uncover the reasons for the particular syndromes a patient "chooses," we must first understand the source and character of the goals he or she seeks to achieve. As elaborated in Millon and Davis (1996), the character of the symptoms a patient chooses has not been a last-minute decision, but reflects a long history of interwoven biogenic and psychogenic factors that have formed his or her basic personality pattern. As noted earlier, in analyzing the distinguishing goals of complex syndromal behaviors, we are led to the following observations: Susceptible patients appear especially desirous of avoiding the negative experiences (pain) of social disapproval and rejection; moreover, where possible, they wish to evoke the positive experiences (pleasure) of attention, sympathy, and nurture.

Although each personality pattern (or syndrome context) has had different prior experiences, they tend to share in common a hypersensitivity to social rebuff and condemnation, to which they hesitate reacting with counteraggression. In the *dependent* patterns, for example, there is a fear of losing the security and rewards that others provide; these patients must guard themselves against acting in such ways as to provoke disapproval and separation; rather, where feasible, they will maneuver themselves to act in ways that evoke favorable responses.

There are endless variations in the *specific* life experiences to which different members of the same personality style or disorder have been exposed. Let us compare, for example, two individuals who have been "trained" to become *compulsive* personalities. One may have been exposed to a mother who was chronically ill, a pattern of behavior that brought her considerable sympathy and freedom from many burdens. With this as a background factor, the person may be inclined to follow the model she observed in her mother when she is faced with undue anxiety and threat, thereby displaying hypochondriacal syndromes. A second compulsive personality may have learned to imitate a father who expressed endless fears about all types of events and situations. In his case, there is a greater likelihood that phobic syndromes would arise in response to stressful and anxiety-laden circumstances. In short, the specific "choice" of the complex syndrome is not a function solely of the patient's personality pattern, but may reflect more particular and entirely incidental events of prior experience and learning.

Although each complex syndrome crops up with greater frequency among certain personalities than others, they do arise in a number of different patterns. For example, *somatoform* syndromes occur most commonly among patients exhibiting a basic avoidant, dependent, histrionic, compulsive, or negativistic personality pattern; *conduct disorders* are found primarily in narcissistic, antisocial, and sadistic patterns. This observation points up the importance of specifying the basic personality style or disorder from which a complex syndrome arises. The dominant symptom a patient displays cannot, in itself, clue us well enough to the basic dispositions and vulnerabilities of the patient. In later chapters, we shall make it a practice to discuss complex clinical syndromes with reference to the specific pathological personality pattern from which they issue.

Three cases of the complex clinical syndrome labeled dysthymia are presented next to illustrate the fact that the appraisal of an Axis I syndrome should be approached in terms of the patient's larger context of personality dispositions and vulnerabilities. In the first of these cases, a dysthymic syndrome is described in a *dependent* personality. In the second, the dysthymia is interpreted as it is likely to occur in a *negativistic* (passive-aggressive) personality. In the third dysthymic description, the characterization of the patient derives its significance in the context of a *masochistic* personality:

Dysthymia in a dependent personality: This woman may be characteristically tense and sad; however, her apprehensiveness appears to have achieved dysphoric levels that are sufficient to classify her as experiencing a mixed anxiety and dysthymic disorder. Dependent and dejected, but also ambivalent about her relationships, she may struggle to restrain her sadness and resentment, but with only partial success. The strain of her vacillations may precipitate a variety of behavioral syndromes, such as restlessness and distractibility, as well as physical discomfort such as insomnia and fatigue. Holding back her dysphoric mood is stressful, but discharging it is equally problematic in that it may provoke those on whom she depends.

Dysthymia in a negativistic personality: A pattern of anxiety and dysthymia is likely to have emerged over time in this edgy and actively ambivalent man. Unsure of the fealty of those on whom he has learned to depend and conflicted about his neediness in this regard, he experiences strong emotions of a resentful and hostile nature. Because of his dread of rebuke and rejection, he tries to restrain these emotions but is only partially successful. Rather than chance total abandonment, he turns much of his anger inward, leading to self-generated feelings of unworthiness and guilt. His increasingly hopeless feeling springs from a wide and pervasive range of events that have caused him to see his life as being filled with inadequacies, resentments, fears, diminished pleasures, and self-doubts.

Dysthymia in a masochistic personality: The self-demeaning comments and feelings of inferiority expressed by this dysthymic woman are part of her overall and enduring characterological structure, a set of chronic self-defeating attitudes and depressive

emotions that are intrinsic to her psychological makeup. Feelings of emptiness and loneliness are mixed with expressions of low self-esteem, preoccupations with ostensive failures and physical unattractiveness, and assertions of guilt and unworthiness. Although she complains about being aggrieved and mistreated, she is likely to assert that she deserves the anguish and abuse she receives. Such self-debasement is consonant with her self-image, as are her tolerance and perpetuation of relationships that foster and aggravate her misery.

Despite the short-term gains made by complex syndromal efforts, the symptoms they give rise to are frequently self-defeating in the end. By restricting their environment (e.g., phobias), limiting their physical competencies (e.g., conversions), preoccupying themselves with distracting activities (e.g., obsessions-compulsions), or deprecating their self-worth (e.g., dysthymia), patients avoid confronting and resolving their real difficulties and tend to become increasingly dependent on others. This psychic maneuver, then, is a double-edged sword. It relieves for the moment passing discomforts and strains, but in the long run fosters the perpetuation of faulty attitudes and coping strategies.

Complex syndromal patients exhibit a blend of several traits and symptoms that rise and subside over time in their clarity and prominence. This complex and changing picture is further complicated by the fact that it is set within the context of the patient's broader personality pattern of attitudes and behaviors. In planning a treatment approach, the therapist is faced with an inextricable mixture of focal and transitory symptoms that are embedded in a pattern of more diffuse and permanent traits.

Separating these clinical features for therapeutic attention is no simple task. To decide which features make up the "basic personality" and which represent the "clinical syndrome" cannot readily be accomplished as both are elements of the same system of vulnerabilities and coping strategies. Even when clear distinctions can be drawn, as when a symptom suddenly emerges in clear and sharp relief, a judgment must be made as to whether therapeutic attention should be directed to the focal symptom or to the "underlying" personality trait pattern from which it has sprung. In certain cases, it is both expeditious and fruitful to concentrate solely on the manifest clinical syndrome; in other cases, however, it may be advisable to rework the more pervasive and ingrained pattern of personality domains.

Before we proceed, let us again be reminded that the descriptive label given to each of the clinical syndromes may be misleading in that it suggests that a single symptom stands alone, uncontaminated by others. This is not the case, especially in what we have termed the complex clinical syndromes. Although a particular symptom may appear dominant at one time, it often coexists and covaries with several others, any one of which may come to assume dominance. As a further complication, there is not only covariation and fluidity in symptomatology, but each of these clinical syndromes arise in a number of different personality patterns.

Much of the confusion that has plagued diagnostic systems in the past can be attributed to this overlapping and changeability of symptom pictures. For reasons

discussed in previous sections, it has been argued that greater clarity can be achieved in diagnosis if we focus on the basic personality of the patient rather than limit ourselves to the particular dominant symptom he or she manifests. Moreover, by focusing our attention on enduring personality traits and pervasive clinical domains of expression, we may be able to deduce the cluster of different symptoms the patient is likely to display and the sequence of symptoms he or she may exhibit over the course of the illness. For example, knowing the vulnerabilities and habitual coping strategies of *paranoid* personalities, we would predict that they will evidence either together or in sequence both delusions and hostile mania, should they become psychotically disordered. Similarly, *compulsive* personalities may be expected to manifest cyclical swings between catatonic rigidity, agitated depression, and manic excitement, should they decompensate into a psychotic state. Focusing on ingrained personality patterns rather than transient symptoms enables us to grasp both the patient's complex syndrome and the symptoms he or she is likely to exhibit, as well as the possible sequence in which they will wax and wane.

Simple Reactions: Focusing on Singular Symptoms

There is a close correspondence in simple clinical reactions between classical assessment *domains* (e.g., *DSM* diagnostic criteria) and modern *therapeutic* modalities. This concurrence greatly facilitates our understanding and selection of optimal techniques of treatment among these reactions. It addresses the long-held desire to connect diagnostic assessment with therapeutic methodology.

Unfortunately, the diagnostic criteria of the *DSM-IV* are both noncomprehensive (no real scheme through which to coordinate and anchor domain attributes has been developed) and noncomparable (the criteria run the gamut from very broad to very narrow). Further, these problems exist both within and between disorders, so that different disorders evince different content distortions. Consider, for example, the Obsessive-Compulsive Personality Disorder. Criterion 5 is relatively narrow and behavioral: "Is unable to discard worn-out or worthless objects even when they have no sentimental value." In contrast, criterion 8 requires more inference: "Shows rigidity and stubbornness." In fact, the inability to discard worthless objects could well be considered simply a behavioral manifestation of the trait of rigidity. Failure to coordinate criteria across domains may also lead to redundancies. Consider, for example, the Dependent Personality Disorder. Criterion 1 states, "Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others." Criterion 2, however, says almost the same: "Needs others to assume responsibility for most major areas of his or her life." In fact, five of the eight dependent personality criteria seem oriented toward the interpersonal conduct domain, two seem oriented toward the self-image domain, and only one is concerned with cognitive style, leaving the domains of regulatory mechanisms, object representations, morphologic organization, mood/temperament, and expressive behavior completely unaddressed.

Failure to multioperationalize psychopathology via comprehensive and comparable symptom domains certainly means that the content validity of the criteria sets has been compromised, quite probably contributing to diagnostic invalidity and therapeutic inefficiency. Because the *DSM* is usually taken as the gold standard by which other measures of psychic pathology are judged, the degree of distortion is an open question at this point—there is no gold standard for the gold standard. The worst-case scenario reads as follows: Clinical wisdom states correctly that, in principle, multiple data sources and construct operationalizations should be sought as a means of obtaining convergent validity for one's assessment findings, where possible. Because the *DSM* criteria sets are noncomprehensive and noncomparable, there are substantive reasons, reasons that go beyond mere principle, for bringing extra-*DSM* notions and instruments to bear on an individual's assessment case. To the extent that *DSM* criteria are successfully operationalized, distortions that are latent in these criteria are built into an instrument, thereby providing users with information confirmatory of a *DSM* diagnosis, but in fact diagnosis is valid only through redundancy. Thus, the role of free-wheeling clinical judgment has by no means been usurped by such instrumentalities and criteria sets (Westen & Weinberger, 2004).

Ideally, a diagnosis functions as a means of narrowing the universe of therapeutic techniques to some small set of choices, and within this small set, uniquely personal factors come into play between alternative techniques or the order in which these techniques might be applied.

Let us *briefly* examine how a few of the simple reaction symptoms correspond to various modes of therapy; more extensive discussions are provided in later chapters of this text.

Therapists who subscribe to the *behavioral* orientation emphasize simple reactions that can be directly observed. As a consequence, their interest centers on environmental stimuli and overt behavioral responses. Most clinical reactions are considered to be deficient or maladaptive learned behaviors. They avoid, where possible, reference to unobservable or subjective processes such as intrapsychic conflicts or cognitive attitudes. Because inner states are anathema to them, they are inclined to an action-suppressive rather than an insight-expressive process. Because the most clearly formulated schema of behavior change has been developed in the laboratories of learning theorists, they borrow their methods and procedures from that body of research. It follows logically, they contend, that simple reactions can best be altered by the same learning principles and procedures that were involved in their acquisition. Thus, behavior therapists design their treatment programs in terms of conditioning and imitative modeling techniques that provide selective rewards and punishments. In this way, simple syndromal behaviors that had been connected to provocative stimuli are systematically eliminated and more adaptive behavioral alternatives carefully formed.

Cognitive therapists believe that treatment for both simple reactions and complex syndromes should be conceived in terms of the patient's beliefs, assumptions, and expectancies. Because individuals react to their present world in accord with their

current perception of it, cognitivists contend that the goal of treatment should not be to unravel the early causes of difficulties, but to assist people in developing a clearer understanding of how their distorted attitudes and beliefs generate and prolong their problems. As their perception of events and people is clarified, they will be able to approach life with fewer problematic assumptions and expectancies, enabling them to act in ways that will eliminate the syndrome in question.

As we know, *intrapsychic* therapists focus their efforts on the elusive and obscure data of the unconscious. To them, the crucial elements underlying most syndromes are repressed childhood anxieties and the unconscious adaptive processes that have evolved to protect against their resurgence. The task of therapy, then, is to unravel these hidden residues of the past and to bring them into consciousness, where they can be reevaluated and reworked in a constructive fashion. Shorn of insidious unconscious forces through the unfolding of self-insight and the uprooting of forbidden feelings, the patient may now be free to explore a more wholesome and productive way of life.

As we know it, the concept of a system must be brought to the forefront, even when discussing reactions and syndromes. Systems function as a whole, but are composed of parts. As noted, we have partitioned mental disorders into simple reactions, complex syndromes, and personality patterns, but we segregated these disorders with reference to the eight structural and functional domains described in the figures and tables in this chapter (Millon, 1984, 1986a, 1990; Millon & Davis, 1996). These domains encompass the greater part of a person's makeup. Simple reactions are essentially expressed in only one major symptom domain (e.g., behavior, relationships); complex syndromes usually engage three or four clinical domains, whereas personality patterns are likely to comprise almost all of the trait domains. They serve as a means of classifying the parts or constructs in accord with established therapeutic traditions. In every complex syndrome, elements from several domains constrain what can exist in other domains of the system. An individual born with a phlegmatic temperament, for example, is unlikely to mature into a histrionic adult. An individual whose primary defensive mechanism is intellectualization is more likely to mature into a schizoid than an antisocial. The nature and intensity of the constraints in each of these domains limit the potential number of states that the system can assume at any moment in time; this total configuration of operative domains results in each patient's distinctive pattern of individuality.

Millon-Grossman Personality Domain Checklist (MG-PDC)

Several words may usefully be said regarding the newly devised MG-PDC instrument (Millon & Grossman, in press). Clinicians and personologists employ numerous sources to obtain assessment data on both persons in general and their patients. These range from incidental to well-structured observations, casual to highly systematic interviews, and cursory to formal analyses of biographic history; also employed are a

variety of laboratory tests, self-report inventories, and performance-based or projective techniques. All of these have proven to be useful grounds for diagnostic study.

How do we put these diverse data sources together to systematize and quantify the information we have gathered? It is toward the end of organizing and maximizing the clinical utility of our personality findings that the MG-PDC has been developed.

On their own, observations and projective techniques are viewed as excessively subjective. Laboratory procedures (e.g., brain imaging) are not yet sufficiently developed, and biographical data are often too unreliable to depend on. And despite their popularity with many a distinguished psychometrician, the utility of self-report inventories is far from universally accepted.

Whether assessment tools are based on empirical investigations, epidemiologic research, mathematical analyses, or theoretical deductions, they often fail to characterize persons in the language and concepts traditionally employed by clinical personologists. Although many instruments have proven of value in numerous research studies, such as demonstrating reasonable intercorrelations or a correspondence with established diagnostic systems (e.g., the *DSM*), many an astute clinician has questioned whether these tools yield anything beyond the reliability of surface impressions. Some (Westen & Weinberger, 2004) doubt whether self-report instruments, for example, successfully tap into or unravel the diverse, complex, and hidden relationships among difficult-to-fathom processes. Other critics have contended that patient-generated responses may contain *no* clinically relevant information beyond the judgments of nonscientists employing the vocabulary of a layperson's lexicon.

Data obtained from patient-based self-judgments may be contrasted with the sophisticated clinical appraisals of mental health professionals. We must ask whether clinical language, concepts, and instruments encoded in the evolving professional language of the past 100 years or so generate information incremental to the naive descriptions of an ordinary person's everyday lexicon. We know that clinical languages differ from laypersons' languages because they serve different and more sophisticated purposes (Livesley, Jackson, & Schroeder, 1989). Indeed, clinical concepts reflect the experienced contributions of numerous historical schools of thought (Millon, 2004). Each of these clinical schools (e.g., psychodynamic, cognitive, interpersonal) have identified a multitude of diverse and complex psychic processes that operate in our mental life. Surely the concepts of these historical professional lexicons are not reducible to the superficial factors drawn from the everyday vocabulary of nonscientists.

It is to represent and integrate the insights and concepts of the several major schools of thought that has led us to formulate a domain-based, clinician-rated assessment (Millon, 1969/1985, 1981, 1984, 1986a, 1990, 1996b; Tringone, 1990, 1997), and now to develop, following numerous empirical and theoretical refinements, the MG-PDC. In contrast with the five-factor method, popular among research-oriented psychologists, the Personality Domain Checklist (PDC) is based on the contributions of five of the major *clinical traditions:* the behavioral, the interpersonal, the self, the cognitive, and the biological. Three optional domains are listed additionally in the

instrument to reflect the psychoanalytic tradition; the use of these intrapsychic domains has diminished in recent decades and they are therefore included as elective, that is, not required components of the instrument.

Several criteria were used to select and develop the clinical domains listed in the checklist: (a) that they be *broad-based and varied* in the features they embody, that is, not limited just to biological temperaments or cognitive processes, but instead encompass a full range of personality characteristics that are based on frequently used clinical terms and concepts; (b) that they correspond to the major *therapeutic modalities* employed by contemporary mental health professionals to treat their patients (e.g., *cognitive* techniques for altering dysfunctional beliefs, group procedures for modifying *interpersonal* conduct) and, hence, are readily employed by practicing therapeutic clinicians; (c) that they be *coordinated with* and reflect the official personality disorder prototypes established by the *International Classification of Diseases* (*ICD*) and *DSM* and, thereby, be understood by insurance and other management professionals; (d) that a *distinctive psychological trait* can be identified and operationalized in each of the clinical trait domains for each personality prototype, assuring thereby both scope and comparability among personological criteria; (e) that they lend themselves to the appraisal of domain characteristics for both *normal and abnormal* personalities and, hence, further promote advances in the field of normality, one of growing interest in the psychological literature; and (f) that they can serve as an *educational clinical tool* to sensitize mental heath workers in training (psychologists, psychiatrists, clinical social workers, etc.) to the many distinctions, subtleties, and domain interactions that are worth considering in appraising personality attributes.

The *integrative perspective* encouraged in the MG-PDC views personalities as a multidetermined and multireferential construct. One, albeit problematic, means by some clinical researchers of dealing with the conceptual alternatives that characterizes personality study today is to oversimplify the task. They choose to assess the patient in accord with a single conceptual orientation, eliminating thereby the integration of divergent perspectives by an act of regressive dogmatism. A truly effective assessment, however, one that is logically consonant with the modern integrative character of personality, both as a construct and as a reality, requires that the individual be assessed systematically across multiple characterological domains, thereby ensuring that the assessment is comprehensive, useful to a broad range of clinicians, and more likely valid. In assessing with the MG-PDC, clinicians should refrain, therefore, from regarding each domain as an independent entity and thereby falling into a naive, single-minded approach. Each of the domains is a legitimate but highly contextualized part of a unified or integrated whole, a necessary composite that ensures that the full integrity of the person is represented.

As noted previously, the domains of the instrument can be organized in a manner similar to distinctions drawn in the biological realm; that is, they may be divided and characterized as *structural* and *functional* attributes. The functional domains of the instrument represent dynamic processes that transpire between the individual and

his or her psychosocial environment. These transactions take place through what we have termed the person's *modes of regulatory action,* that is, his or her demeanor, social relations, and thought processes, each of which serve to manage, adjust, transform, coordinate, and control the give-and-take of inner and outer life. Several functional domains relevant to each personality are included among the major components of the MG-PDC.

In contrast to the functional characteristics, structural domains represent templates of deeply embedded affect dispositions and imprinted memories, attitudes, needs, and conflicts that guide experience and orient ongoing life events. These domains may be conceived as *quasi-permanent substrates for identity and temperament.* These residues of the past and relatively enduring affects effectively constrain and even close off innovative learnings and limit new possibilities to already established habits and dispositions. Their persistent and preemptive character perpetuates the maladaptive behavior and vicious circles of a patient's extant personality pathology.

Of course, individuals differ with respect to the domains they enact most frequently. People vary not only in the degree to which they approximate each personality prototype but also in the extent to which each domain dominates their behavior. In conceptualizing personality as a system, we must recognize that different parts of the system will be dominant in different individuals, even when those individuals are patients who share the same prototypal diagnosis. It is the goal of the MG-PDC to *differentiate, operationalize,* and *measure quantitatively* those domain features that are primary in contributing to the person's functioning. Thus identified, the instrument should help orient the clinical therapist to modify the person's problematic features (e.g., interpersonal conduct, cognitive beliefs), and thereby enable the patient to acquire a greater variety of adaptive behaviors in his or her life circumstances.

The reader may wish to review the trait options that constitute the choices for each of the domains. While reading and thinking about the several domain descriptions, and to help guide your choices, feel comfortable in moving freely, back and forth, as you proceed. For example, while working on reviewing the trait options for the Expressive Behavior domain, do not hesitate to look at the trait descriptions for any of the other domains (e.g., Interpersonal Conduct) if by doing so you may be aided in understanding the characteristics of the Expressive Behavior group of choices.

For each of the following domain pages, beginning with Expressive Behavior, you will see 15 descriptive trait choices. Locate the descriptive choice that appears to you to *best fit* in characterizing a patient you may be thinking about. You would encircle that choice in the 1st best fit column.

Because most people can be characterized by more than one expressive behavior trait, locate a second-best-fit descriptive characteristic, one not as applicable to this person as the first best fit you selected, but notable nonetheless. Encircle the 2nd best fit choice.

Should there be other listed descriptive trait features that are applicable to this person, but less so than the one selected as second best, encircle the 3rd best fit choice.

You may encircle up to three choices in the 3rd best fit column. (Note that only one trait description may be marked in each of the 1st and 2nd best fit columns.)

Consider the following points as you proceed. The 15 descriptive traits for each domain were written to characterize patients. Further, each trait is illustrated with several clinical characteristics and examples. Note that the person you are rating need not display precisely the characteristics that are listed; they need only be the best fit of the listed group of features. It is important to note also that for rated persons of a nonclinical character, that is, normal personalities who display only minor or mild aspects of the trait characteristic, you should, nevertheless, fully mark the best-fit columns (even though the descriptor is characterized with a more serious clinical description than suits the person). In short, *do not* leave any of the best-fit columns blank. Fill them in, in rank best-fit order, even when the features of the trait are only marginally present.

After completing ratings for the Expressive Behavior domain, you would proceed to fill in your choices for the next seven domains, one at a time, using the same first, second, and third ratings you followed previously.

Because readers of this text are not actually completing the following MG-PDC judgment forms, it will be useful for them to know which personality prototype corresponds to the letters that precede each of the descriptors. For example, in the Expressive Behavior domain, note that the letter A precedes the first descriptor, "Impassive." The letter A signifies that this descriptor characterizes the Retiring/Schizoid Prototype. Each of the following letters on all eight domains corresponds to the following associated prototypes:

A. Retiring/Schizoid
B. Eccentric/Schizotypal
C. Shy/Avoidant
D. Needy/Dependent
E. Exuberant/Hypomanic
F. Sociable/Histrionic
G. Confident/Narcissistic
H. Suspicious/Paranoid
I. Nonconforming/Antisocial
J. Assertive/Sadistic
K. Pessimistic/Melancholic (Depressive)
L. Aggrieved/Masochistic
M. Skeptical/Negativistic
N. Capricious/Borderline
O. Conscientious/Compulsive

Table 1.1 *MG-PDC* I. Expressive Behavior DOMAIN

These attributes relate to observables at the *behavioral level* of emotion and are usually recorded by noting how the patient acts. Through inference, observations of overt behavior enable us to deduce what the patient unknowingly reveals about his or her emotions or, often conversely, what he or she wants others to think about him or her. The range and character of expressive actions are wide and diverse and they convey distinctive and worthwhile clinical information, from communicating a sense of personal incompetence to exhibiting emotional defensiveness to demonstrating disciplined self-control, and so on.

1st Best Fit	2nd Best Fit	3rd Best Fit	Characteristic Behavior
1	2	3	***A. Impassive:*** Is colorless, sluggish, displaying deficits in activation and emotional expressiveness; appears to be in a persistent state of low energy and lack of vitality (e.g., phlegmatic and lacking in spontaneity).
1	2	3	***B. Peculiar:*** Is perceived by others as eccentric, disposed to behave in an unobtrusively aloof, curious, or bizarre manner; exhibits socially gauche habits and aberrant mannerisms (e.g., manifestly odd or eccentric).
1	2	3	***C. Fretful:*** Fearfully scans environment for social derogation; overreacts to innocuous events and judges them to signify personal derision and mockery (e.g., anxiously anticipates ridicule/humiliation).
1	2	3	***D. Incompetent:*** Ill-equipped to assume mature and independent roles; is passive and lacking functional competencies, avoiding self-assertion and withdrawing from adult responsibilities (e.g., has difficulty doing things on his or her own).
1	2	3	***E. Impetuous:*** Is forcefully energetic and driven, emotionally excitable and overzealous; often worked up, unrestrained, rash, and hotheaded (e.g., is restless and socially intrusive).
1	2	3	***F. Dramatic:*** Is histrionically overreactive and stimulus-seeking, resulting in unreflected and theatrical responsiveness; describes penchant for sensational situations and short-sighted hedonism (e.g., overly emotional and artificially affected).
1	2	3	***G. Haughty:*** Manifests an air of being above conventional rules of shared social living, viewing them as naive or inapplicable to self; reveals an egocentric indifference to the needs of others (e.g., acts arrogantly self-assured and confident).

Table 1.1 (*Continued*)

1st Best Fit	2nd Best Fit	3rd Best Fit	Characteristic Behavior
1	2	3	***H. Defensive:*** Is vigilantly guarded, hyperalert to ward off anticipated deception and malice; is tenaciously resistant to sources of external influence (e.g., disposed to be wary, envious, and jealous).
1	2	3	***I. Impulsive:*** Since adolescence, acts thoughtlessly and irresponsibly in social matters; is shortsighted, heedless, incautious, and imprudent, failing to plan ahead or consider legal consequences (e.g., Conduct Disorder evident before age 15).
1	2	3	***J. Precipitate:*** Is stormy and unpredictably abrupt, reckless, thick-skinned, and unflinching, seemingly undeterred by pain; is attracted to challenge, as well as undaunted by punishment (e.g., attracted to risk, danger, and harm).
1	2	3	***K. Disconsolate:*** Appearance and posture convey an irrelievably forlorn, heavy-hearted, if not grief-stricken quality; markedly dispirited and discouraged (e.g., somberly seeks others to be protective).
1	2	3	***L. Abstinent:*** Presents self as nonindulgent, frugal, and chaste, refraining from exhibiting signs of pleasure or attractiveness; acts in an unpresuming and self-effacing manner, placing self in an inferior light (e.g., undermines own good fortune).
1	2	3	***M. Resentful:*** Exhibits inefficiency, erratic, contrary, and irksome behaviors; reveals gratification in undermining the pleasures and expectations of others (e.g., uncooperative, contrary, and stubborn).
1	2	3	***N. Spasmodic:*** Displays a desultory energy level with sudden, unexpected self-punitive outbursts; endogenous shifts in emotional state places behavioral equilibrium in constant jeopardy (e.g., does impulsive, self-damaging acts).
1	2	3	***O. Disciplined:*** Maintains a regulated, emotionally restrained, and highly organized life; often insists that others adhere to personally established rules and methods (e.g., meticulous and perfectionistic).

Table 1.2 *MG-PDC* II. Interpersonal Conduct DOMAIN

A patient's style of relating to others may be captured in a number of ways, such as how his or her actions affect others, intended or otherwise; the attitudes that underlie, prompt, and give shape to these actions; the methods by which he or she engages others to meet his or her needs; and his or her way of coping with social tensions and conflicts. Extrapolating from these observations, the clinican may construct an image of how the patient functions in relation to others.

1st Best Fit	2nd Best Fit	3rd Best Fit	Characteristic Conduct
1	2	3	***A. Unengaged:*** Is indifferent to the actions or feelings of others, possessing minimal "human" interests; ends up with few close relationships and a limited role in work and family settings (e.g., has few desires or interests).
1	2	3	***B. Secretive:*** Strives for privacy, with limited personal attachments and obligations; drifts into increasingly remote and clandestine social activities (e.g., is enigmatic and withdrawn).
1	2	3	***C. Aversive:*** Reports extensive history of social anxiety and isolation; seeks social acceptance, but maintains careful distance to avoid anticipated humiliation and derogation (e.g., is socially pan-anxious and fearfully guarded).
1	2	3	***D. Submissive:*** Subordinates needs to a stronger and nurturing person, without whom will feel alone and anxiously helpless; is compliant, conciliatory, and self-sacrificing (e.g., generally docile, deferential, and placating).
1	2	3	***E. High-Spirited:*** Is unremittingly full of life and socially buoyant; attempts to engage others in an animated, vivacious, and lively manner; often seen by others, however, as intrusive and needlessly insistent (e.g., is persistently overbearing).
1	2	3	***F. Attention-Seeking:*** Is self-dramatizing, and actively solicits praise in a showy manner to gain desired attention and approval; manipulates others and is emotionally demanding (e.g., seductively flirtatious and exhibitionistic).
1	2	3	***G. Exploitive:*** Acts entitled, self-centered, vain, and unempathic; expects special favors without assuming reciprocal responsibilities; shamelessly takes others for granted and uses them to enhance self and indulge desires (e.g., egocentric and socially inconsiderate).

Table 1.2 (*Continued*)

1st Best Fit	2nd Best Fit	3rd Best Fit	Characteristic Conduct
1	2	3	***H. Provocative:*** Displays a quarrelsome, fractious, and distrustful attitude; bears serious grudges and precipitates exasperation by a testing of loyalties and a searching preoccupation with hidden motives (e.g., unjustly questions fidelity of spouse/friend).
1	2	3	***I. Irresponsible:*** Is socially untrustworthy and unreliable, intentionally or carelessly failing to meet personal obligations of a marital, parental, employment, or financial nature; actively violates established civil codes through duplicitous or illegal behaviors (e.g., shows active disregard for rights of others).
1	2	3	***J. Abrasive:*** Reveals satisfaction in competing with, dominating, and humiliating others; regularly expresses verbally abusive and derisive social commentary, as well as exhibiting harsh, if not physically brutal behavior (e.g., intimidates, coerces, and demeans others).
1	2	3	***K. Defenseless:*** Feels and acts vulnerable and guilt-ridden; fears emotional abandonment and seeks public assurances of affection and devotion (e.g., needs supportive relationships to bolster hopeless outlook).
1	2	3	***L. Deferential:*** Relates to others in a self-sacrificing, servile, and obsequious manner, allowing, if not encouraging others to exploit or take advantage; is self-abasing, accepting undeserved blame and unjust criticism (e.g., courts others to be exploitive and mistreating).
1	2	3	***M. Contrary:*** Assumes conflicting roles in social relationships, shifting from dependent acquiescence to assertive independence; is obstructive toward others, behaving either negatively or erratically (e.g., sulky and argumentative in response to requests).
1	2	3	***N. Paradoxical:*** Needing extreme attention and affection, but acts unpredictably and manipulatively and is volatile, frequently eliciting rejection rather than support; reacts to fears of separation and isolation in angry, mercurial, and often self-damaging ways (e.g., is emotionally needy, but interpersonally erratic).
1	2	3	***O. Respectful:*** Exhibits unusual adherence to social conventions and proprieties; prefers polite, formal, and "correct" personal relationships (e.g., interpersonally proper and dutiful).

Table 1.3 *MG-PDC* III. Cognitive Style/Content DOMAIN

How the patient focuses and allocates attention, encodes and processes information, organizes thoughts, makes attributions, and communicates reactions and ideas to others represents key cognitive functions of clinical value. These characteristics are among the most useful indices of the patient's distinctive way of thinking. By synthesizing his or her beliefs and attitudes, it may be possible to identify indications of problematic cognitive functions and assumptions.

1st Best Fit	2nd Best Fit	3rd Best Fit	Characteristic Cognitive Style
1	2	3	***A. Impoverished:*** Seems deficient in human spheres of knowledge and evidences vague thought processes about everyday matters that are below intellectual level; social communications are easily derailed or conveyed via a circuitous logic (e.g., lacks awareness of human relations).
1	2	3	***B. Autistic:*** Intrudes social communications with personal irrelevancies; there is notable circumstantial speech, ideas of reference, and metaphorical asides; is ruminative, appears self-absorbed and lost in occasional magical thinking; there is a marked blurring of fantasy and reality (e.g., exhibits peculiar ideas and superstitious beliefs).
1	2	3	***C. Distracted:*** Is bothered by disruptive and often distressing inner thoughts; the upsurge from within of irrelevant and digressive ideation upsets thought continuity and interferes with social communications (e.g., withdraws into reveries to fulfill needs).
1	2	3	***D. Naive:*** Is easily persuaded, unsuspicious, and gullible; reveals a Pollyanna attitude toward interpersonal difficulties, watering down objective problems and smoothing over troubling events (e.g., childlike thinking and reasoning).
1	2	3	***E. Scattered:*** Thoughts are momentary and scrambled in an untidy disarray with minimal focus to them, resulting in a chaotic hodgepodge of miscellaneous and haphazard beliefs expressed randomly with no logic or purpose (e.g., intense and transient emotions disorganize thoughts).
1	2	3	***F. Flighty:*** Avoids introspective thought and is overly attentive to trivial and fleeting external events; integrates experiences poorly, resulting in shallow learning and thoughtless judgments (e.g., faddish and responsive to superficialities).
1	2	3	***G. Expansive:*** Has an undisciplined imagination and exhibits a preoccupation with illusory fantasies of success, beauty, or love; is minimally constrained by objective reality; takes liberties with facts and seeks to redeem boastful beliefs (e.g., indulges fantasies of repute/power).

Table 1.3 (*Continued*)

1st Best Fit	2nd Best Fit	3rd Best Fit	Characteristic Cognitive Style
1	2	3	***H. Mistrustful:*** Is suspicious of the motives of others, construing innocuous events as signifying conspiratorial intent; magnifies tangential or minor social difficulties into proofs of duplicity, malice, and treachery (e.g., wary and distrustful).
1	2	3	***I. Deviant:*** Construes ordinary events and personal relationships in accord with socially unorthodox beliefs and morals; is disdainful of traditional ideals and conventional rules (e.g., shows contempt for social ethics and morals).
1	2	3	***J. Dogmatic:*** Is strongly opinionated, as well as unbending and obstinate in holding to his or her preconceptions; exhibits a broad social intolerance and prejudice (e.g., closed-minded and bigoted).
1	2	3	***K. Fatalistic:*** Sees things in their blackest form and invariably expects the worst; gives the gloomiest interpretation of current events, believing that things will never improve (e.g., conceives life events in persistent pessimistic terms).
1	2	3	***L. Diffident:*** Is hesitant to voice his or her views; often expresses attitudes contrary to inner beliefs; experiences contrasting and conflicting thoughts toward self and others (e.g., demeans own convictions and opinions).
1	2	3	***M. Cynical:*** Skeptical and untrusting, approaching current events with disbelief and future possibilities with trepidation; has a misanthropic view of life, expressing disdain and caustic comments toward those who experience good fortune (e.g., envious or disdainful of those more fortunate).
1	2	3	***N. Vacillating:*** Experiences rapidly changing, fluctuating, and antithetical perceptions or thoughts concerning passing events; contradictory reactions are evoked in others by virtue of his or her behaviors, creating, in turn, conflicting and confusing social feedback (e.g., erratic and contrite over own beliefs and attitudes).
1	2	3	***O. Constricted:*** Constructs world in terms of rules, regulations, time schedules, and social hierarchies; is unimaginative, indecisive, and notably upset by unfamiliar or novel ideas and customs (e.g., preoccupied with lists, details, rules, etc.).

Table 1.4 *MG-PDC* IV. Self-Image DOMAIN

As the inner world of symbols is mastered through development, one major configuration emerges to impose a measure of sameness on an otherwise fluid environment: the perception of self-as-object, a distinct, ever-present identity. Self-image is significant in that it serves as a guidepost and lends continuity to changing experience. Most patients have an implicit sense of who they are but differ greatly in the clarity, accuracy, and complexity of their introspection of the psychic elements that make up this image.

1st Best Fit	2nd Best Fit	3rd Best Fit	Characteristic Self-Image
1	2	3	***A. Complacent:*** Reveals minimal introspection and awareness of self; seems impervious to the emotional and personal implications of his or her role in everyday social life (e.g., minimal interest in own personal life).
1	2	3	***B. Estranged:*** Possesses permeable ego boundaries, exhibiting acute social perplexities and illusions as well as experiences of depersonalization, derealization, and dissociation; sees self as "different," with repetitive thoughts of life's confusions and meaninglessness (e.g., self-perceptions are haphazard and fragmented).
1	2	3	***C. Alienated:*** Sees self as a socially isolated person, one rejected by others; devalues self-achievements and reports feelings of aloneness and undesirability (e.g., feels injured and unwanted by others).
1	2	3	***D. Inept:*** Views self as weak, fragile, and inadequate; exhibits lack of self-confidence by belittling own aptitudes and competencies (e.g., sees self as childlike and/or fragile).
1	2	3	***E. Energetic:*** Sees self as full of vim and vigor, a dynamic force, invariably hardy and robust, a tireless and enterprising person whose ever-present energy galvanizes others (e.g., proud to be active and animated).
1	2	3	***F. Gregarious:*** Views self as socially stimulating and charming; enjoys the image of attracting acquaintances and pursuing a busy and pleasure-oriented social life (e.g., perceived as appealing and attractive, but shallow).
1	2	3	***G. Admirable:*** Confidently exhibits self, acts in a self-assured manner, and publicly displays achievements, despite being seen by others as egotistic, inconsiderate, and arrogant (e.g., has a sense of high self-worth).

Table 1.4 (*Continued*)

1st Best Fit	2nd Best Fit	3rd Best Fit	Characteristic Self-Image
1	2	3	***H. Inviolable:*** Is highly insular, experiencing intense fears of losing identity, status, or powers of self-determination; nevertheless, has persistent ideas of self-reference, asserting as personally derogatory and scurrilous entirely innocuous actions and events (e.g., sees ordinary life events as invariably referring to self).
1	2	3	***I. Autonomous:*** Values the sense of being free, unencumbered, and unconfined by persons, places, obligations, or routines; sees self as unfettered by the restrictions of social customs and the restraints of personal loyalties (e.g., values being independent of social responsibilities).
1	2	3	***J. Combative:*** Values aspects of self that present tough, domineering, and power-oriented image; is proud to characterize self as unsympathetic and unsentimental (e.g., proud to be stern and feared by others).
1	2	3	***K. Worthless:*** Sees self as valueless, of no account, a person who should be overlooked, owing to having no praiseworthy traits or achievements (e.g., sees self as insignificant or inconsequential).
1	2	3	***L. Undeserving:*** Focuses on and amplifies the very worst features of self; judges self as worthy of being shamed, humbled, and debased; has failed to live up to the expectations of others and, hence, should be reproached and demeaned (e.g., sees self as deserving to suffer).
1	2	3	***M. Discontented:*** Sees self as unjustly misunderstood and unappreciated; recognizes that he or she is characteristically resentful, disgruntled, and disillusioned with life (e.g., sees self as unfairly treated).
1	2	3	***N. Uncertain:*** Experiences the marked confusions of a nebulous or wavering sense of identity and self-worth; seeks to redeem erratic actions and changing self-presentations with expressions of contrition and self-punitive behaviors (e.g., has persistent identity disturbances).
1	2	3	***O. Reliable:*** Sees self as industrious, meticulous, and efficient; fearful of error or misjudgment and, hence, overvalues aspects of self that exhibit discipline, perfection, prudence, and loyalty (e.g., sees self as reliable and conscientious).

Table 1.5 *MG-PDC* V. Mood/Affect DOMAIN

Few observables are more clinically relevant than the predominant character of an individual's affect and the intensity and frequency with which he or she expresses it. The meaning of extreme emotions is easy to decode. This is not so with the more subtle moods and feelings that insidiously and repetitively pervade the patient's ongoing relationships and experiences. The expressive features of mood/affect may be revealed, albeit indirectly, in activity level, speech quality, and physical appearance.

1st Best Fit	2nd Best Fit	3rd Best Fit	Characteristic Mood
1	2	3	***A. Apathetic:*** Is emotionally impassive, exhibiting an intrinsic unfeeling, cold, and stark quality; reports weak affectionate or erotic needs, rarely displaying warm or intense feelings, and apparently unable also to experience either sadness or anger (e.g., unable to experience pleasure in depth).
1	2	3	***B. Distraught or Insentient:*** Reports being *either* apprehensive and ill at ease, particularly in social encounters; anxiously watchful, distrustful of others, and wary of their motives; *or* manifests drab, sluggish, joyless, and spiritless appearance; reveals marked deficiencies in emotional expression and in face-to-face encounters (e.g., highly agitated and/or affectively flat).
1	2	3	***C. Anguished:*** Vacillates between desire for affection, fear of rebuff, and numbness of feeling; describes constant and confusing undercurrents of tension, sadness, and anger (e.g., unusually fearful of new social experiences).
1	2	3	***D. Pacific:*** Quietly and passively avoids social tension and interpersonal conflicts; is typically pleasant, warm, tender, and noncompetitive (e.g., characteristically timid and uncompetitive).
1	2	3	***E. Mercurial:*** Volatile and quicksilverish, at times unduly ebullient, charged up, and irrepressible; at other times, flighty and erratic emotionally, blowing hot and cold (e.g., has marked penchant for momentary excitements).
1	2	3	***F. Fickle:*** Displays short-lived and superficial emotions; is dramatically overreactive and exhibits tendencies to be easily enthused and as easily bored (e.g., impetuously pursues pleasure-oriented social life).

Table 1.5 (*Continued*)

1st Best Fit	2nd Best Fit	3rd Best Fit	Characteristic Mood
1	2	3	***G. Insouciant:*** Manifests a general air of nonchalance and indifference; appears coolly unimpressionable or calmly optimistic, except when self-centered confidence is shaken, at which time either rage, shame, or emptiness is briefly displayed (e.g., generally appears imperturbable and composed).
1	2	3	***H. Irascible:*** Displays a sullen, churlish, and humorless demeanor; attempts to appear unemotional and objective, but is edgy, touchy, surly, quick to react angrily (e.g., ready to take personal offense).
1	2	3	***I. Callous:*** Exhibits a coarse incivility, as well as a ruthless indifference to the welfare of others; is unempathic, as expressed in wide-ranging deficits in social charitableness, human compassion, or personal remorse (e.g., experiences minimal guilt or contrition for socially repugnant actions).
1	2	3	***J. Hostile:*** Has an overtly rough and pugnacious temper, which flares periodically into contentious argument and physical belligerence; is fractious, willing to do harm, even persecute others to get own way (e.g., easily embroiled in brawls).
1	2	3	***K. Woeful:*** Is typically mournful, tearful, joyless, and morose; characteristically worrisome and brooding; low spirits rarely remit (e.g., frequently feels dejected or guilty).
1	2	3	***L. Dysphoric:*** Intentionally displays a plaintive and gloomy appearance, occasionally to induce guilt and discomfort in others (e.g., drawn to relationships in which he or she will suffer).
1	2	3	***M. Irritable:*** Is often petulant, reporting being easily annoyed or frustrated by others; typically obstinate and resentful, followed in turn by sulky and grumpy withdrawal (e.g., impatient and easily provoked into oppositional behavior).
1	2	3	***N. Labile:*** Fails to accord unstable moods with external reality; has marked shifts from normality to depression to excitement, or has extended periods of dejection and apathy, interspersed with brief spells of anger, anxiety, or euphoria (e.g., mood changes erratically from sadness to bitterness to torpor).
1	2	3	***O. Solemn:*** Is unrelaxed, tense, joyless, and grim; restrains overtly warm or covertly antagonistic feelings, keeping most emotions under tight control (e.g., affect is constricted and confined).

Table 1.6 *MG-PDC* VI. Intrapsychic Mechanisms DOMAIN

Although mechanisms of self-protection, need gratification, and conflict resolution are consciously recognized at times, they represent data derived primarily at the intrapsychic level. Because the ego or defense mechanisms are internal regulatory processes, they are more difficult to discern and describe than processes that are anchored closer to the observable world. As such, they are not directly amenable to assessment by self-reflective appraisal in their pure form but only as derivatives that are potentially many levels removed from their core conflicts and their dynamic resolution. Despite the methodological problems they present, the task of identifying which mechanisms are most characteristic of a patient and the extent to which they are employed is extremely useful in a comprehensive clinical assessment.

1st Best Fit	2nd Best Fit	3rd Best Fit	Characteristic Mechanism
1	2	3	***A. Intellectualization:*** Describes interpersonal and affective experiences in a matter-of-fact, abstract, impersonal, or mechanical manner; pays primary attention to formal and objective aspects of social and emotional events.
1	2	3	***B. Undoing:*** Bizarre mannerisms and idiosyncratic thoughts appear to reflect a retraction or reversal of previous acts or ideas that have stirred feelings of anxiety, conflict, or guilt; ritualistic or "magical" behaviors serve to repent for or nullify assumed misdeeds or "evil" thoughts.
1	2	3	***C. Fantasy:*** Depends excessively on imagination to achieve need gratification and conflict resolution; withdraws into reveries as a means of safely discharging affectionate as well as aggressive impulses.
1	2	3	***D. Introjection:*** Is firmly devoted to another to strengthen the belief that an inseparable bond exists between them; jettisons any independent views in favor of those of another to preclude conflicts and threats to the relationship.
1	2	3	***E. Magnification:*** Engages in hyperbole, overstating and overemphasizing ordinary matters so as to elevate their importance, especially features that enhance not only his or her own virtues but those of others who are valued.
1	2	3	***F. Dissociation:*** Regularly alters self presentations to create a succession of socially attractive but changing façades; engages in self-distracting activities to avoid reflecting on/integrating unpleasant thoughts/emotions.
1	2	3	***G. Rationalization:*** Is self-deceptive and facile in devising plausible reasons to justify self-centered and socially inconsiderate behaviors; offers alibis to place self in the best possible light, despite evident shortcomings or failures.

Table 1.6 (*Continued*)

1st Best Fit	2nd Best Fit	3rd Best Fit	Characteristic Mechanism
1	2	3	***H. Projection:*** Actively disowns undesirable personal traits and motives and attributes them to others; remains blind to own unattractive behaviors and characteristics, yet is overalert to and hypercritical of the defects of others.
1	2	3	***I. Acting Out:*** Inner tensions that might accrue by postponing the expression of offensive thoughts and malevolent actions are rarely constrained; socially repugnant impulses are not refashioned in sublimated forms, but are discharged directly in precipitous ways, usually without guilt.
1	2	3	***J. Isolation:*** Can be cold-blooded and remarkably detached from an awareness of the impact of his or her destructive acts; views objects of violation impersonally, often as symbols of devalued groups devoid of human sensibilities.
1	2	3	***K. Asceticism:*** Engages in acts of self-denial, self-tormenting, and self-punishment, believing that one should exhibit penance and not be rewarded with life's bounties; not only is there a repudiation of pleasures but there are harsh self-judgments and minor self-destructive acts.
1	2	3	***L. Exaggeration:*** Repetitively recalls past injustices and seeks out future disappointments as a means of raising distress to troubled homeostatic levels; misconstrues, if not sabotages, personal good fortunes to enhance or maintain preferred suffering and pain.
1	2	3	***M. Displacement:*** Discharges anger and other troublesome emotions either indirectly or by shifting them from their true objective to settings or persons of lesser peril; expresses resentments by substitute or passive means, such as acting inept or perplexed, or behaving in a forgetful or indolent manner.
1	2	3	***N. Regression:*** Retreats under stress to developmentally earlier levels of anxiety tolerance, impulse control, and social adaptation; is unable or disinclined to cope with responsible tasks and adult issues, as evident in immature, if not increasingly childlike behaviors.
1	2	3	***O. Reaction Formation:*** Repeatedly presents positive thoughts and socially commendable behaviors that are diametrically opposite to his or her deeper, contrary, and forbidden feelings; displays reasonableness and maturity when faced with circumstances that normally evoke anger or dismay in most persons.

Table 1.7 *MG-PDC* VII. Intrapsychic Content DOMAIN

Significant experiences from the past leave an inner imprint, a structural residue composed of memories, attitudes, and affects that serve as a substrate of dispositions for perceiving and reacting to life's events. Analogous to the various organ systems in the body, both the character and the substance of these internalized representations of significant figures and relationships from the past can be differentiated and analyzed for clinical purposes. Variations in the nature and content of this inner world, or what are often called *object relations*, can be identified with one or another personality and lead us to employ the following descriptive terms to represent them.

1st Best Fit	2nd Best Fit	3rd Best Fit	Characteristic Content
1	2	3	***A. Meager:*** Inner representations are few in number and minimally articulated, largely devoid of the manifold percepts and memories, or the dynamic interplay among drives and conflicts that typify even well-adjusted persons.
1	2	3	***B. Chaotic:*** Inner representations consist of a jumble of miscellaneous memories and percepts, random drives and impulses, and uncoordinated channels of regulation that are only fitfully competent for binding tensions, accommodating needs, and mediating conflicts.
1	2	3	***C. Vexatious:*** Inner representations are composed of readily reactivated, intense, and anxiety-ridden memories, limited avenues of gratification, and few mechanisms to channel needs, bind impulses, resolve conflicts, or deflect external stressors.
1	2	3	***D. Immature:*** Inner representations are composed of unsophisticated ideas and incomplete memories, rudimentary drives and childlike impulses, as well as minimal competencies to manage and resolve stressors.
1	2	3	***E. Piecemeal:*** Inner representations are disorganized and dissipated, a jumble of diluted and muddled recollections that are recalled by fits and starts, serving only as momentary guideposts for dealing with everyday tensions and conflicts.
1	2	3	***F. Shallow:*** Inner representations are composed largely of superficial yet emotionally intense affects, memories, and conflicts, as well as facile drives and insubstantial mechanisms.
1	2	3	***G. Contrived:*** Inner representations are composed far more than usual of illusory ideas and memories, synthetic drives and conflicts, and pretentious, if not simulated, percepts and attitudes, all of which are readily refashioned as the need arises.

Table 1.7 (*Continued*)

1st Best Fit	2nd Best Fit	3rd Best Fit	Characteristic Content
1	2	3	***H. Unalterable:*** Inner representations are arranged in an unusual configuration of rigidly held attitudes, unyielding percepts, and implacable drives, which are aligned in a semidelusional hierarchy of tenacious memories, immutable cognitions, and irrevocable beliefs.
1	2	3	***I. Debased:*** Inner representations are a mix of revengeful attitudes and impulses oriented to subvert established cultural ideals and mores, as well as to debase personal sentiments and conventional societal attainments.
1	2	3	***J. Pernicious:*** Inner representations are distinguished by the presence of aggressive energies and malicious attitudes, as well as by a contrasting paucity of sentimental memories, tender affects, internal conflicts, shame, or guilt feelings.
1	2	3	***K. Forsaken:*** Inner representations have been depleted or devitalized, either drained of their richness and joyful elements or withdrawn from memory, leaving the person to feel abandoned, bereft, discarded.
1	2	3	***L. Discredited:*** Inner representations are composed of disparaged past memories and discredited achievements, of positive feelings and erotic drives transposed onto their least attractive opposites, of internal conflicts intentionally aggravated, of mechanisms of anxiety reduction subverted by processes that intensify discomforts.
1	2	3	***M. Fluctuating:*** Inner representations compose a complex of opposing inclinations and incompatible memories that are driven by impulses designed to nullify his or her own achievements and/or the pleasures and expectations of others.
1	2	3	***N. Incompatible:*** Rudimentary and expediently devised, but repetitively aborted, inner representations have led to perplexing memories, enigmatic attitudes, contradictory needs, antithetical emotions, erratic impulses, and opposing strategies for conflict reduction.
1	2	3	***O. Concealed:*** Only those inner affects, attitudes, and actions that are socially approved are allowed conscious awareness or behavioral expression, resulting in gratification being highly regulated, forbidden impulses sequestered and tightly bound, personal and social conflicts defensively denied, kept from awareness, all maintained under stringent control.

Table 1.8 *MG-PDC* VIII. Intrapsychic Structure DOMAIN

The overall architecture that serves as a framework for an individual's psychic interior may display weakness in its structural cohesion, exhibit deficient coordination among its components, and possess few mechanisms to maintain balance and harmony, regulate internal conflicts, or mediate external pressures. The concept of intrapsychic structure refers to the organizational strength, interior congruity, and functional efficacy of the personality system, a concept almost exclusively derived from inferences at the *intrapsychic* level of analysis. Psychoanalytic usage tends to be limited to quantitative degrees of integrative pathology, not to *qualitative variations* in either integrative structure or configuration. Stylistic variants of this structural attribute, such as the following, may be employed to characterize each of the personality prototypes.

1st Best Fit	2nd Best Fit	3rd Best Fit	Characteristic Structure
1	2	3	***A. Undifferentiated:*** Given an inner barrenness, a feeble drive to fulfill needs, and minimal pressures to defend against or resolve internal conflicts, or to cope with external demands, internal structures may best be characterized by their limited coordination and deficient organization.
1	2	3	***B. Fragmented:*** Coping and defensive operations are haphazardly organized in a fragile assemblage, leading to spasmodic and desultory actions in which primitive thoughts and affects are directly discharged, with few reality-based sublimations, leading to significant further structural disintegrations.
1	2	3	***C. Fragile:*** Tortuous emotions depend almost exclusively on a single modality for their resolution and discharge, that of avoidance, escape, and fantasy; hence, when faced with unanticipated stress, there are few resources available to deploy and few positions to revert to, short of a regressive decompensation.
1	2	3	***D. Inchoate:*** Owing to entrusting others with the responsibility to fulfill needs and to cope with adult tasks, there is both a deficit and a lack of diversity in internal structures and controls, leaving a miscellany of relatively undeveloped and immature adaptive abilities and elementary systems for independent functioning.
1	2	3	***E. Fleeting:*** Structures are highly transient, existing in momentary forms that are cluttered and disarranged, making effective coping efforts temporary at best. Affect and action are unconstrained owing to the paucity of established controls and purposeful goals.

Table 1.8 (*Continued*)

1st Best Fit	2nd Best Fit	3rd Best Fit	Characteristic Structure
1	2	3	***F. Disjointed:*** A loosely knit structural conglomerate exists in which processes of internal regulation and control are scattered and unintegrated, with few methods for restraining impulses, coordinating defenses, and resolving conflicts, leading to broad and sweeping mechanisms to maintain psychic cohesion and stability and, when employed, only further disarrange thoughts, feelings, and actions.
1	2	3	***G. Spurious:*** Coping and defensive strategies tend to be flimsy and transparent, appear more substantial and dynamically orchestrated than they are, regulating impulses only marginally, channeling needs with minimal restraint, and creating an egocentric inner world in which conflicts are dismissed, failures are quickly redeemed, and self-pride is effortlessly reasserted.
1	2	3	***H. Inelastic:*** A markedly constricted and inflexible pattern of coping and defensive methods exists, as well as rigidly fixed channels of conflict mediation and need gratification, creates an overstrung and taut frame that is so uncompromising in its accommodation to changing circumstances that unanticipated stressors are likely to precipitate either explosive outbursts or inner shatterings.
1	2	3	***I. Unruly:*** Inner defensive operations are noted by their paucity, as are efforts to curb irresponsible drives and attitudes, leading to easily transgressed social controls, low thresholds for impulse discharge, few subliminatory channels, unfettered self-expression, and a marked intolerance of delay or frustration.
1	2	3	***J. Eruptive:*** Despite a generally cohesive structure of routinely modulating controls and expressive channels, surging, powerful, and explosive energies of an aggressive and sexual nature produce precipitous outbursts that periodically overwhelm and overrun otherwise reasonable restraints.
1	2	3	***K. Depleted:*** The scaffold for structures is markedly weakened, with coping methods enervated and defensive strategies impoverished and devoid of vigor and focus, resulting in a diminished if not exhausted capacity to initiate action and regulate affect.
1	2	3	***L. Inverted:*** Structures have a dual quality, one more or less conventional, the other its obverse—resulting in a repetitive undoing of affect and intention, of a transposing of channels of need gratification with those leading to their frustration, and of actions that produce antithetical, if not self-sabotaging consequences.

(*continued*)

Table 1.8 (*Continued*)

1st Best Fit	2nd Best Fit	3rd Best Fit	Characteristic Structure
1	2	3	***M. Divergent:*** There is a clear division in the pattern of internal elements such that coping and defensive maneuvers are often directed toward incompatible goals, leaving major conflicts unresolved and psychic cohesion impossible, as fulfillment of one drive or need inevitably nullifies or reverses another.
1	2	3	***N. Split:*** Inner cohesion constitutes a sharply segmented and conflictful configuration with a marked lack of consistency among elements; levels of consciousness occasionally blur; a rapid shift occurs across boundaries separating unrelated memories/affects, results in schisms upsetting limited extant psychic order.
1	2	3	***O. Compartmentalized:*** Psychic structures are rigidly organized in a tightly consolidated system that is clearly partitioned into numerous distinct and segregated constellations of drive, memory, and cognition, with few open channels to permit any interplay among these components.

On the basis of your knowledge of the person you have evaluated, using the domain categories listed in Tables 1.1 through 1.8, summarize your judgments by making an overall first-, second-, and third-best-fit personality spectrum diagnosis on Table 1.9. If you wish, before you proceed to Table 1.9, you may want to go back to review your eight domain best choices and *double encircle* the three that you judge most important to be therapeutically modified.

Table 1.9 Spectra that Best Characterize the Person

1st Best Fit	2nd Best Fit	3rd Best Fit	Normal to Abnormal Personality Spectrum
1	2	3	Retiring—Schizoid
1	2	3	Eccentric—Schizotypal
1	2	3	Shy—Avoidant
1	2	3	Needy—Dependent
1	2	3	Exuberant—Hypomanic
1	2	3	Sociable—Histrionic
1	2	3	Confident—Narcissistic
1	2	3	Suspicious—Paranoid
1	2	3	Nonconforming—Antisocial

Table 1.9 (*Continued*)

1st Best Fit	2nd Best Fit	3rd Best Fit	Normal to Abnormal Personality Spectrum
1	2	3	Assertive—Sadistic
1	2	3	Pessimistic—Melancholic
1	2	3	Aggrieved—Masochistic
1	2	3	Skeptical—Negativistic
1	2	3	Capricious—Borderline
1	2	3	Conscientious—Compulsive

As earlier, we would like you to further evaluate the person you have just rated using the preceding eight domain characteristics. In Table 1.10 please assess his or her current overall level of social and occupational functioning. Make your judgment using the 7-point continuum, which ranges from Excellent to Markedly Impaired. Focus your rating on the individual's present mental state and social competencies, overlooking where possible physical impairments or socioeconomic considerations. Circle the number on the chart that closely approximates your best judgment.

Table 1.10 Overall Level of Social and Occupational Functioning

Judgment	Rating Number	Description
Excellent	1	Clearly manifests an effective, if not superior level of functioning in relating to family and social peers, even to helping others in resolving their difficulties, as well as demonstrating high occupational performance and success.
Very Good	2	Exhibits considerable social and occupational skills on a reasonably consistent basis, evidencing few if any major areas of interpersonal stress or occupational difficulty.
Good	3	Displays a higher than average level of social and occupational competence in ordinary matters of everyday life. He or she does experience intermittent difficulties in interpersonal relationships and in efforts to achieve work satisfaction.
Fair	4	Functions about average for a typical patient seen in outpatient clinical work. Although able to meet everyday family, social, and occupational responsibilities adequately, there remain problematic or extended periods of occupational stress and/or interpersonal conflict.

(*continued*)

Table 1.10 (*Continued*)

Judgment	Rating Number	Description
Poor	5	Able to be maintained on an outpatient basis, but often precipitates severe conflicts with others that upset his or her equanimity in either or both interpersonal relationships and occupational settings.
Very Poor	6	There is an inability to function competently in most social and occupational settings. Difficulties are precipitated by the patient, destabilizing job performance and upsetting relationships with significant others. Inpatient hospitalization may be necessary to manage periodic severe psychic disruptions.
Markedly Impaired	7	A chronic and marked disintegration is present across most psychic functions. The loss of physical and behavioral controls necessitate extended stays in residential or hospital settings, requiring both sustained care and self-protection.

General Methods and Goals of Personalized Psychotherapy

We will return to many of the numerous guiding principles and issues touched on in this extensive chapter as we proceed to the following chapters of this and subsequent books in the three-part personalized psychotherapy series. Many themes characterizing our rationale for personalized psychotherapy have been presented and argued in the preceding pages. It is hoped that these themes and justifications will become more clearly evident to the reader as we move forward to the next chapters and books.

Potentiated Pairings and Catalytic Sequences

What procedures contributed to making personalized therapy individualized and synergized rather than eclectic?

To restate from earlier paragraphs, there is a separateness among eclectically designed techniques, just a wise selectivity of what works best. In personalized therapy there are psychologically designed *composites* and *progressions* among diverse techniques. In an attempt to formulate them in current writings (Millon, 1988), terms such as "catalytic sequences" and "potentiated pairings" are employed to represent the nature and intent of theory-based polarity- and domain-oriented treatment plans. In

essence, they comprise therapeutic arrangements and timing series that will resolve each patient's distinctive polarity imbalances and effect targeted clinical domain changes that would otherwise not occur by the use of several essentially uncoordinated techniques.

The first of the *personalized procedures* we recommended some years ago (Millon, 1988, 1990) was termed "potentiated pairings"; these are treatment methods that are *combined simultaneously* to overcome problematic characteristics that might be refractory to each technique if administered separately. These composites pull and push for change on many different fronts, so that the therapy becomes as multioperational and as tenacious as the disorder itself. A recent and popular illustration of treatment pairings is found in what has been referred to as cognitive-behavior therapy, one of the first of the combinatorial therapies (Craighead, Craighead, Kazdin, & Mahoney, 1994; Rasmussen, 2005).

In the second personalized procedure, termed "catalytic sequences," one might seek first to alter a patient's humiliating and painful stuttering by *behavior modification* procedures, which, if achieved, may facilitate the use of *cognitive or self-actualizing* methods to produce changes in self-confidence, which may, in its turn, foster the utility of *interpersonal* techniques in effecting improvements in relationships with others. Catalytic sequences are timing series that should optimize the impact of changes that would be less effective if the sequential combination were otherwise arranged.

A more recent example has begun to show up in numerous clinical reports this past decade (Slater, 1998). It relates to the fact that patients with depressive personalities or long-term dysthymic disorders have their clinical symptoms markedly reduced by virtue of pharmacologic medications (e.g., selective serotonin reuptake inhibitors [SSRIs]). Although these patients are greatly comforted by the reduction of their clinical symptoms, "depressiveness" has over time become a core part of their overall psychological makeup. Because their depressiveness is no longer a part of their everyday experience, many may now feel empty and confused, not knowing who they are, not knowing to what they may aspire, or how to relate to the world. It is here where a catalytic sequence of psychotherapies may come into play constructively. Patients may no longer be depressed, but they may require therapy for their new self-image and its valuation. No less important to their subsequent treatment will be opportunities to alter their formerly habitual interpersonal styles and attitudes, substituting in their stead social behaviors and cognitions that are more consonant with their current state. Former cognitive assumptions and expectations will no longer be infused with depressogenic elements calling for substantial psychic reformulations.

As the great neurological surgeon and psychologist Kurt Goldstein (1940) stated, patients whose brains have been altered to remedy a major neurological disorder do not simply lose the function that the extirpated area subserved. Rather, patients restructure and reorganize their brain capacities so that they can maintain an integrated sense of self. In a similar way, when one or another major domain of patients' habitual psychological makeup is removed or diminished (e.g., depression), the patients must reorganize themselves, not only to compensate for the loss, but also *to formulate a new self.*

Similarly, the neurologist Oliver Sacks in his 1973 book *Awakenings* describes what happens to patients who had been immobile for decades by encephalitis lethargica who suddenly "unfroze" when given the drug L-Dopa. Although these patients were restored to life, they had to learn to function in a world that had long passed them by. For them, their immobile state had an element of familiarity in which they had learned to cope, miserable though it was, for 10, 20, or 30 years. With the elimination of their adaptive lifestyle, they now had to deal with the new world in which they found themselves, a task that rarely can be managed without considerable guidance and encouragement. Catalytic sequences represent the steps that should be employed in succession to facilitate these relearning and reintegrative processes.

There are no discrete boundaries between potentiated pairings and catalytic sequences, just as there is no line between their respective pathological analogues, that is, adaptive inflexibility and vicious circles (Millon, 1969/1985). Nor should therapists be concerned about when to use one rather than another. Instead, they are intrinsically interdependent phenomena whose application is intended to foster increased flexibility and, hopefully, a virtuous rather than a vicious circle. Potentiated pairings and catalytic sequences represent the logic of combinatorial therapies. The idea of a potentiated sequence or a catalytic pairing recognizes that these logical composites may build on each other in proportion to what the tenacity of the patient's interwoven disorder domains require.

One question concerns the limits to which the content of personalized therapy can be specified in advance, that is, the extent to which specific potentiated pairings and catalytic sequences can be identified for each of the typical complex syndromes and personality disorders that exist. Many of the chapters of this and later texts of this series contain charts that present the salience of each of the clinical domains for that syndrome or disorder. To the extent that each patient's presentations are prototypal, the potentiated pairings and catalytic sequences that may be used should derive from the more or less typical modality tactics that are optimal for their problematic domains, for example, pharmacology for mood/affect. That, however, probably represents the limits to which theory or "therapies that work" can guide clinical practice, that is, without knowing anything about the history and characteristics of the *specific individual case.* Patient individuality is so rich and special that it cannot fit into any ideal taxonomic schema; personalized therapy, properly practiced, is full of specificities that cannot readily be resolved by classification generalities. Potentiated pairings, catalytic sequences, and whatever other higher order composites therapists may evolve are best conducted at an idiographic person level rather than at a nomothetic taxonomic level. Accordingly, their precise content is specified as much by the logic of the individual case as by the logic of the syndrome or disorder. At an idiographic level, each of us must ultimately be artful and open-minded therapists, using simultaneous or alternately focused methods. The synergism and enhancement produced by such catalytic and potentiating processes is what constitute genuinely innovative personalized treatment strategies.

Personalized therapists will be more efficacious if they think about the likely utility of treatment choices in probabilistic terms; that is, they should make concurrent and sequential modality arrangements, knowing that the effectiveness of each component is only partial, and that the probability of success will be less than perfect. To generate a high-probability estimate, therapists must gather all available assessment information and, as do mathematicians, calculate which combination of modalities will have the highest overall probability of being effective. Note that no combinational approach can automatically be judged "best." With each new patient, a therapist should recognize that he or she is dealing with a person whose composite of dispositions and vulnerabilities has never before existed in this exact form. Moreover, it is important that the personalized therapist never think in treatment absolutes, or in black-and-white results; all treatment modalities have reasonable probabilities of success.

There will be many cases in which the pattern of a patient's characteristics does not lend itself to an intelligent estimate of treatment success probabilities. Under such circumstances, therapists should not feel that they must create a long-term or overall plan. Available options in the early stages of treatment may not provide a good, no less an excellent, course of action. Such indeterminate states favor selecting a rather tentative or conservative course—until such time as greater clarity emerges. It should be evident from the foregoing comments that a personalized therapist will be challenged to make a series of difficult judgments, one more demanding and possibly with less assurance as to outcome than if the therapist routinely selected a specific modality for all or most of his or her cases. The latter course will be easier for the therapist, but not necessarily best for the patient. The remainder of this and other books of this series will seek to make the probabilistic task less indeterminate and less onerous. We will attempt to provide a rationale for which modalities and which combinations are likely to be most effective, given the pattern of the patient's clinical syndromes and personality disorders.

Theory-Based Polarity Goals

Among the points stated earlier in the book, we should select our specific treatment techniques as tactics to achieve polarity-oriented goals. Depending on the pathological polarity, the domains to be modified, and the overall treatment sequence one has in mind, the goals of therapy should be oriented toward the improvement of imbalanced or deficient polarities by the use of techniques that are optimally suited to modify their expression in those clinical domains that account for the imbalance or deficiency.

Therapeutic efforts responsive to problems in the *pain-pleasure polarity* would, for example, have as their essential aim the enhancement of pleasure among schizoid, avoidant, and depressive personalities (+ pleasure). Given the probability of intrinsic deficits in this area, *schizoids* might require the use of pharmacologic agents designed to activate their flat mood/ temperament. Increments in pleasure for *avoidants,* however, are likely to depend more on cognitive techniques designed to alter their alienated self-image and behavioral methods oriented to counter their aversive interpersonal

inclination. Equally important for avoidants is reducing their hypersensitivities, especially to social rejection (− pain); this may be achieved by coordinating the use of medications for their characteristic anguished mood/temperament with cognitive methods geared to their desensitization. In the *passive-active* polarity, increments in the capacity and skills to take a less reactive and more proactive role in dealing with the affairs of their lives (− passive; + active) would be a major goal of treatment for schizoids, depressives, dependents, narcissists, masochists, and compulsives. Turning to the *other-self* polarity, imbalances found among narcissists and antisocials, for example, suggest that a major aim of their treatment would be a reduction in their predominant self-focus and a corresponding augmentation of their sensitivity to the needs of others (+ other; − self).

To make unbalanced or deficient polarities the primary aim of therapy is a new focus and a goal only moderately tested. In contrast, the clinical domains in which problems are expressed lend themselves to a wide variety of therapeutic techniques, the efficacy of which must, of course, continue to be gauged by ongoing experience and future systematic research. Nevertheless, our repertoire here is a rich one. For example, there are numerous cognitive-behavioral techniques, such as assertiveness training, that may fruitfully be employed to establish a greater sense of autonomy or an active rather than a passive stance with regard to life. Similarly, pharmaceuticals are notably efficacious in reducing the intensity of pain (anxiety, depression) when the pleasure-pain polarity is in marked imbalance.

Selecting Domain Tactics

Turning to the specific domains in which clinical problems exhibit themselves, we can address dysfunctions in the realm of interpersonal conduct by employing any number of family or group therapeutic methods, as well as a series of recently evolved and explicitly formulated interpersonal techniques. Methods of classical analysis or its more contemporary schools may be especially suited to the realm of object representations, as would the methods of Beck and Ellis be well chosen to modify difficulties of cognitive beliefs and self-esteem.

Tactics and *strategies* keep in balance the two conceptual ingredients of therapy; the first refers to what goes on with a particular focused intervention, and the second refers to the overall plan or design that characterizes the entire course of therapy. Both are required. Tactical specificity without strategic goals implies doing without knowing why in the big picture, and goals without specificity implies knowing where to go but having no way to get there. Obviously, one uses short-term modality tactics to accomplish higher level strategies or goals over the long term.

Psychotherapies seem to vary in the amounts of tactical specificity and strategic goals they prefer. This is not often merely an accident of history, but can be tied back to assumptions latent in the therapies themselves. Historically, a progression seems to be toward both greater specificity and clearer goals. More modern approaches

to psychotherapy, such as the cognitive-behavioral, put into place highly detailed elements (e.g., agreed upon goals, termination criteria, and ongoing assessments) in which therapy itself becomes a self-regulating system. Ongoing assessments ensure the existence of a feedback process that is open to inspection and negotiation by both therapist and patient. The mode is one of action rather than talk. Talk is viewed as incapable of realizing possibilities in and of itself, but is merely a prerequisite for action, used to reframe unfortunate circumstances so that obstacles to action are removed or minimized. Action is more transactive than talk, and therapy is forward-looking and concentrates on realizing present possibilities as a means of creating or opening up new possibilities. Persons are often changed more through exposure and action than by focusing and unraveling the problems of the past. Insight may be a useful, even necessary but limited goal in itself.

It must be remembered that the primary function of any system is homeostasis. In an early book (Millon, 1981), personality was likened to an immune system for the psyche, such that stability, constancy, and internal equilibrium become the goals of a personality. Obviously, these run directly in opposition to the explicit goal of therapy, which is change. Usually, the dialogue between patient and therapist is not so directly confrontational that it is experienced as particularly threatening. When the patient does feel threatened, the personality system functions for the patient as a form of passive resistance, albeit one that may be experienced as a positive force (or trait) by the therapist. In fact, the structural grounding of a patient's self-image and object representations are so preemptive and confirmation seeking that the true meaning of the therapist's comments may never reach the level of conscious processing. Alternatively, even if a patient's equilibrium is initially up-ended by a particular interpretation, his or her defensive mechanisms may kick in to ensure that a therapist's comments are somehow distorted, misunderstood, interpreted in a less threatening manner, or even ignored. The first is a passive form of resistance, the second an active form. No wonder, then, that effective therapy is often considered anxiety provoking, for it is in situations where the patient really has no effective response, where the functioning of the psychic immune system is temporarily suppressed, that the scope of his or her response repertoire is most likely to be broadened. Personality goes with what it knows, and it is with the unknown where learning is most possible.

If the psychic makeup of a person is regarded as a system, then the question becomes: How can the characteristics that define systems be co-opted to facilitate rather than retard change? A coordinated schema of strategic goals and tactical modalities for treatment that seeks to accomplish these ends are what we expect to achieve in personalized psychotherapy. Through various coordinated approaches that mirror the system-based composition of the patient's complex clinical syndrome and personality disorder, an effort is made to select domain-focused tactics that will fulfill the strategic goals of treatment.

If interventions are unfocused, rambling, and diffuse, the patient will merely lean forward a little, passively resisting change by using his or her own weight, that is, habitual characteristics already intrinsic to the system. Although creating rapport is always

important, nothing happens unless the system is eventually shook up in some way. Therapists should not always be toiling to expose their patient's defenses, but sooner or later, something must happen that cannot be readily fielded by habitual processes, something that often will be experienced as uncomfortable or even threatening.

In fact, personalized therapy appears in many ways to be like a "punctuated equilibrium" (Eldridge & Gould, 1972) rather than a slow and continuous process. This evolutionary insight argues for periods of rapid growth during which the psychic system reconfigures itself into a new gestalt, alternating with periods of relative constancy. The purpose of keeping to a domain or tactical focus, or knowing clearly what you are doing and why you are doing it, is to keep the whole of the therapeutic enterprise from becoming diffused. The person-focused systems model runs counter to the deterministic universe-as-machine model of the late nineteenth century, which features slow but incremental gains. In the prepunctuated evolutionary model as applied to therapy, moderate interventions become an input that is processed gradually and homeostatically, producing minor, if not zero change. In these earlier procedures, conservation laws play a prominent role; mild interventions produce small increments of change, with the hope that therapeutic goals will be reached, given enough time and effort. In contrast, in a focused, "punctuated" personalized model, therapeutic advances may clearly be spelled out to have genuine transformational potential, a potential optimized through procedures such as those we have termed potentiated pairings and catalytic sequences.

Tactical specificity is required in part because the psychic level in which therapy is practiced is fairly explicit. Most often, the in-session dialogue between patient and therapist is dominated by a discussion of specific domain behaviors, specific domain feelings, and specific domain cognitions, not by an abstract discussion of personality disorders or clinical syndromes. When the latter are discussed, they are often perceived by the patient as an ego-alien or intrusive characterization. A statement such as "You have a negativistic personality that should be changed" conceives the patient as a vessel to be filled or altered by some noxious substance. Under these conditions, the professional is expected to empty the vessel and refill it with something more desirable; the patient has relinquished control and responsibility and simply waits passively for the therapist to perform some mystical ritual, one of the worst assumptive sets in which to carry out psychotherapy.

For the therapist, operationalizing clinical syndromes and personality disorders as domain clusters of expressive behaviors or cognitive styles can be especially beneficial in selecting tactical modalities. The *avoidant's* social withdrawal can be seen as having enough pride in oneself to leave a humiliating situation. The *dependent's* clinging to a significant other can be seen as having the strength to devote oneself to another's care. Of course, these reframes will not be sufficient in and of themselves to produce change. They do, however, seek a bond with the patient by way of making positive attributions and thereby raising self-esteem, while simultaneously working to disconfirm or make the patient reexamine other beliefs that lower esteem and function to keep the person closed off from trying on new roles and behaviors.

Understanding traits as domain clusters of behaviors and/or cognitions is just as beneficial for the therapist as for the patient when it comes to overturning the medical model of syndromal and personality pathology and replacing it with a personalized model. One of the problems of complex syndromes and personality disorders is that their range of attributions and perceptions is too narrow to characterize the richness that in fact exists in their social environment. As a result, they end up perpetuating old problems by interpreting even innocuous behaviors and events as noxious. Modern therapists have a similar problem, in that the range of paradigms they have to bring to their syndromal and disordered patients is too narrow to describe the rich set of possibilities that exist for every individual. The belief that mental difficulties are medical diseases, monolithically fixed and beyond remediation, should itself be viewed as a form of iatrogenic pathology.

As has been noted previously, there are *strategic goals* of therapy, that is, those that endure across numerous sessions and against which progress is measured, and there are specific *domain modality* tactics by which these goals are pursued. Ideally, strategies and tactics should be integrated, with the tactics chosen to accomplish strategic goals, and the strategies chosen on the basis of what tactics might actually achieve, given other constraints, such as the number of therapy sessions and the nature of the problem. To illustrate, intrapsychic therapies are highly strategic but tactically impoverished; pure behavioral therapies are highly tactical but strategically narrow and inflexible. There are, in fact, many different ways that strategies might be operationalized. Just as diagnostic criteria are neither necessary nor sufficient for membership in a given class, it is likely that no technique is an inevitable consequence of a given clinical strategy. Subtle variations in technique and the ingenuity of individual therapists to invent techniques ad hoc assure that there exists an almost infinite number of ways to operationalize or put into action a given clinical strategy.

Individuals should be viewed as system units that exist within larger ecological milieus, such as dyads, families, communities, and, ultimately, cultures. Like the personality system, these higher level systems contain homeostatic processes that tend to sustain and reinforce their own unique patterning of internal variables. The fact that the ecology of complex clinical syndromes and personality disorders is itself organizational and systemic argues for another principle of therapy: Pull as much of the surrounding interpersonal and social context into the therapeutic process as possible, or risk being defeated by them. Where ecological factors are operative, therapeutic gains may be minimized and the risk of relapse increased. In the best-case scenario, family members can be brought into therapy as a group or as needed; if no latent pathologies exist, the family will cooperate in discussing characteristics of the status quo that perpetuate pathology and explore alternatives that might promote change. In the worst-case scenario, family members will refuse to come into therapy under some thin rationale, probably because nonparticipation is one way to passively undermine a change they in fact fear. If family members are not motivated to assist in the therapeutic process, it is likely that the individual is in therapy either because he

or she must be, as in cases of court referral, or because family members do not want the burden of guilt that would accrue from actively refusing assistance.

Procedural Caveats and Considerations

All personalized therapies must consider several factors following the implementation of the general plan. First, progress must be evaluated on a fairly regular basis; second, problems of resistance and risk should be analyzed and counteracted; and third, efforts should be made to anticipate and prevent relapsing.

In personalized therapies, where things hopefully will change rapidly, treatment review should be a continuous process, every few sessions or so. The purpose of evaluating the plan is to ensure that progress is directed to achieving its strategic goals. Part of the evaluation process is intended to give the therapist a rough sense of how long treatment will be. Should progress be delayed or fail to reach a reasonable level, then it is clear that some rethinking of goals and strategies is called for. Evaluating the progress of therapy is difficult when treatment is unstructured or when the time commitment is limited. Personalized therapy may begin with a series of explicit goals and modalities; however, these may change over time, especially if treatment is open-ended (Bergin & Lambert, 1978).

Originally planned strategies and modalities are periodically found lacking. Therapies start with a limited set of impressions and with only a rough notion of the more complex elements of the patient's makeup. As treatment proceeds and knowledge of the patient grows and becomes more thoroughly understood, this new information may strengthen the original plan and strategy; on the other hand, as the assessment process continues, so may the conception of the patient's psychic difficulties be altered. A fine-tuning process may be called for. The overall configuration of syndromes and disorders may require a significant shift toward the use of different domain-oriented modalities. Hence, both strategies and tactics may have to be modified to accord with this new information.

There are numerous issues that arise with patients as therapy progresses. Some patients are highly resistant to the probing and psychic dislodging they experience in treatment. Others feel they have become free from their original constraints, employing treatment as a rationale to engage in increasingly risky activities. Therapeutic resistance derives from the patient's defensive armor, usually indicating a reluctance to voice his or her feelings and thoughts to the therapist. Most *resistances* manifest themselves in a number of well-known ways: silence, lateness, becoming helpless, missed appointments, having significant memory lapses, or simply paying later and later each month. On the other hand, *risky* behaviors are likely to show themselves in a tendency to act out, to be open with regard to expressing resentments, proving the therapist is wrong, exhibiting parasuicidal behaviors, and engaging in irrational behaviors. As Messer (1996) has noted, however, resistances are not the enemy of

therapy but an informative expression of the way patients feel, act, and think in everyday life.

There are several choices when resistances or risks present themselves. We can insist on continuing with the original plan; we can interpret the meaning of the resistance and point out the consequences of risky behaviors; or we can alter aspects of the overall treatment strategy. Whatever the choice will be, it should be formulated as a positive and active decision. Otherwise, the whole structure of the treatment plan may be seriously compromised.

Despite substantial progress over the treatment course, patients should leave therapy in a better state than when they entered. A worst-case scenario is when certain fundamental aspects of the patient's psychic makeup have remained unresolved at the point of treatment termination. Whether it is the patient's decision that he or she has had enough therapy, or the therapist believes that there will be diminishing returns for continuing further, it may be advisable at some point to terminate treatment.

It is the task of the good personalized therapist to help the patient anticipate potential setbacks, to avoid stressful situations in which the patient may be highly vulnerable, and to assist him or her to develop problem-solving skills, as well as to strengthen his or her more constructive potentials. It is not uncommon to have patients develop new psychic symptoms during the treatment process. More typically, many patients experience a reassertion of pathological thoughts and feelings following termination. We strongly encourage therapists to stretch the time between sessions as therapy progresses. This enables the therapist to determine which aspects of the treatment strategy have been resolved adequately and which remain vulnerable and potentially problematic. It is our general belief that adequate therapy should continue over these periodic sessions to ensure that substantial relapses will not occur. The reemergence of certain symptoms does not mean that the patient has deteriorated, but that the more complex elements of the patient's psyche have come together with life circumstances in an especially troublesome way. Such symptoms serve as clues to both the therapist and the patient, enabling them to learn and anticipate what will continue to be troublesome in the future.

The system we have termed personalized therapy has raised concerns by some as to whether any one therapist can be sufficiently skilled, not only in employing a wide variety of therapeutic approaches, but also to synthesize them and to plan their sequence. As the senior author was asked at a conference some years ago: "Can a highly competent behavioral therapist employ cognitive techniques with any measure of efficacy; and can he or she prove able, when necessary, to function as an insightful intrapsychic therapist? Can we find people who are strongly self-actualizing in their orientation who can, at other times, be cognitively confronting? Is there any wisdom in selecting different modalities in treating a patient if the therapist has not been trained diversely or is not particularly competent in more than one ore two therapeutic modalities?"

It is our belief that the majority of therapists have the ability to break out of their single-minded or loosely eclectic frameworks, to overcome their prior limitations, and to acquire a solid working knowledge of diverse treatment modalities. Developing a measure of expertise with the widest possible range of modalities is highly likely to increase treatment efficacy and the therapist's rate of success.

In the following chapters and books of this series, we provide an initial framework for utilizing the personalized approach in a wide range of clinical syndromes and personality disorders. The next section of this text addresses those difficulties that are assigned to Axis I of the *DSM-IV,* primarily simple reactions and clinical syndromes, the latter signifying the interaction of the multiple domains, especially as they constitute personality styles. The second and third books of this series will address each of the prototypal personality disorders covered in Axis II of the *DSM-IV.* Not only will a mix of therapeutic modalities be described to help disentangle and treat each of these prototypal disorders, but illustrations will be presented for many personality subtypes.