PART ONE

CHAPTER 1

Personalized Psychotherapy: A Recapitulation

This chapter is written for readers not fully acquainted with Chapter 1 of the first book, *Resolving Difficult Clinical Syndromes*, of this *Personalized Psychotherapy* series (Millon & Grossman, 2007). It provides a brief synopsis of the essential themes and rationale of this new approach to psychotherapy.

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.

"Personalized" is therefore 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 recognition 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, 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).

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.

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 bridgebuilders (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.

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 they have 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, 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. 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.

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 the *Diagnostic and Statistical Manual of Mental Disorders* (*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.

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.

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 to be 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.

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.

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

extensive elaboration of these ideas (Millon & Bloom, in press; Millon & Davis, 1996; Millon & Grossman, 2006).

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

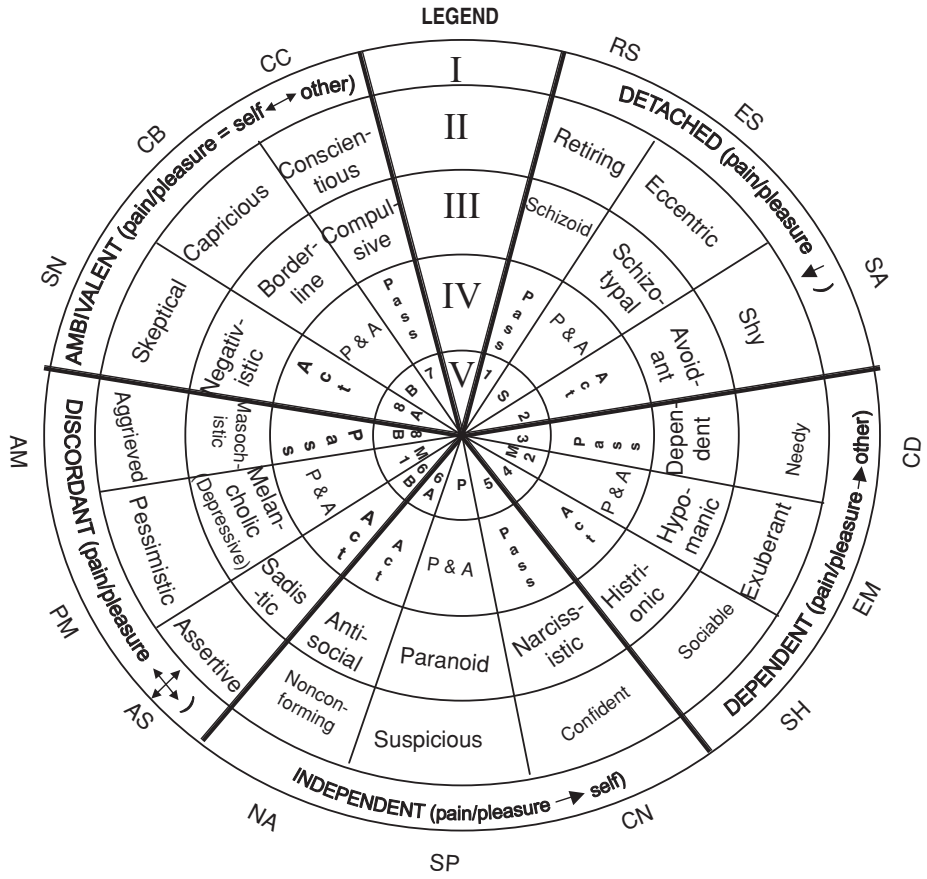

FIGURE 1.1 Personality spectra circulargram I: Normal and abnormal personality patterns. Evolutionary foundations of the normal and abnormal extremes of each personality prototype of the 15 spectra. I: Evolutionary Orientation; II: Normal Prototype; III: Abnormal Prototype; IV: Adaptation Style; V: MCMI-III-E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

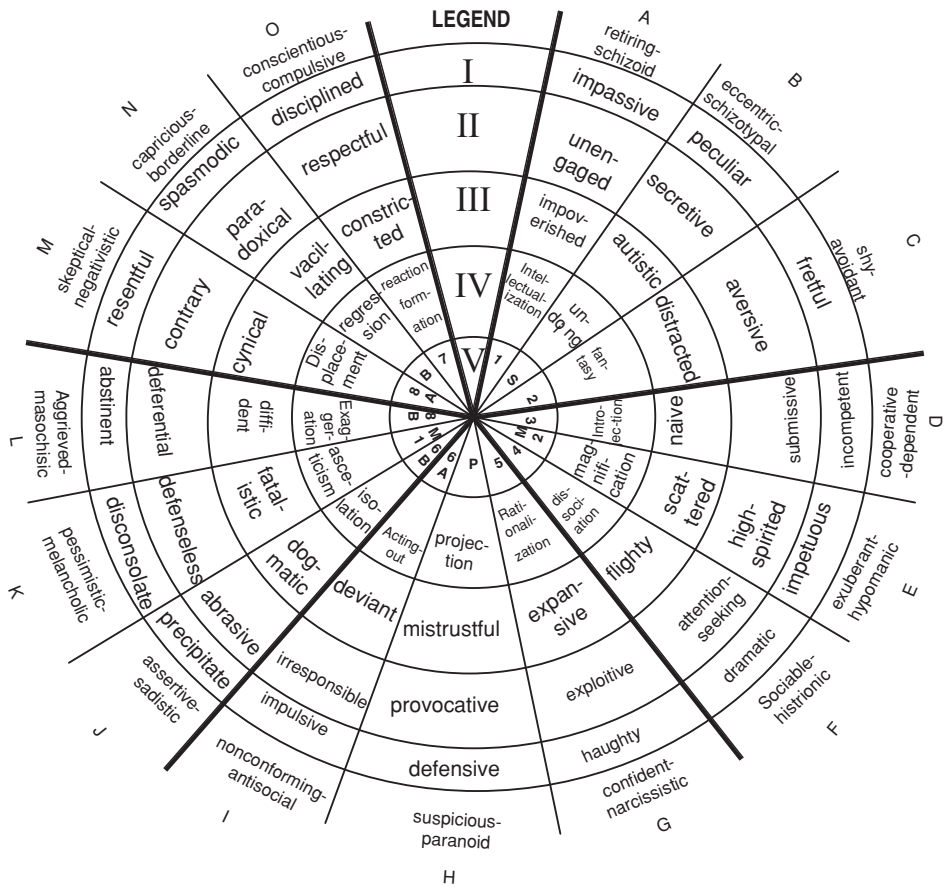

FIGURE 1.2 Personality circulargram IIA: Functional personologic domains. I: Expressive Behavior; II: Interpersonal Conduct; III: Cognitive Style/Content; IV: Intrapsychic Mechanisms; V: MCMI-III Scale.

interpersonal conduct (e.g., the retiring/schizoid's conduct is noted as unengaged). 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.,

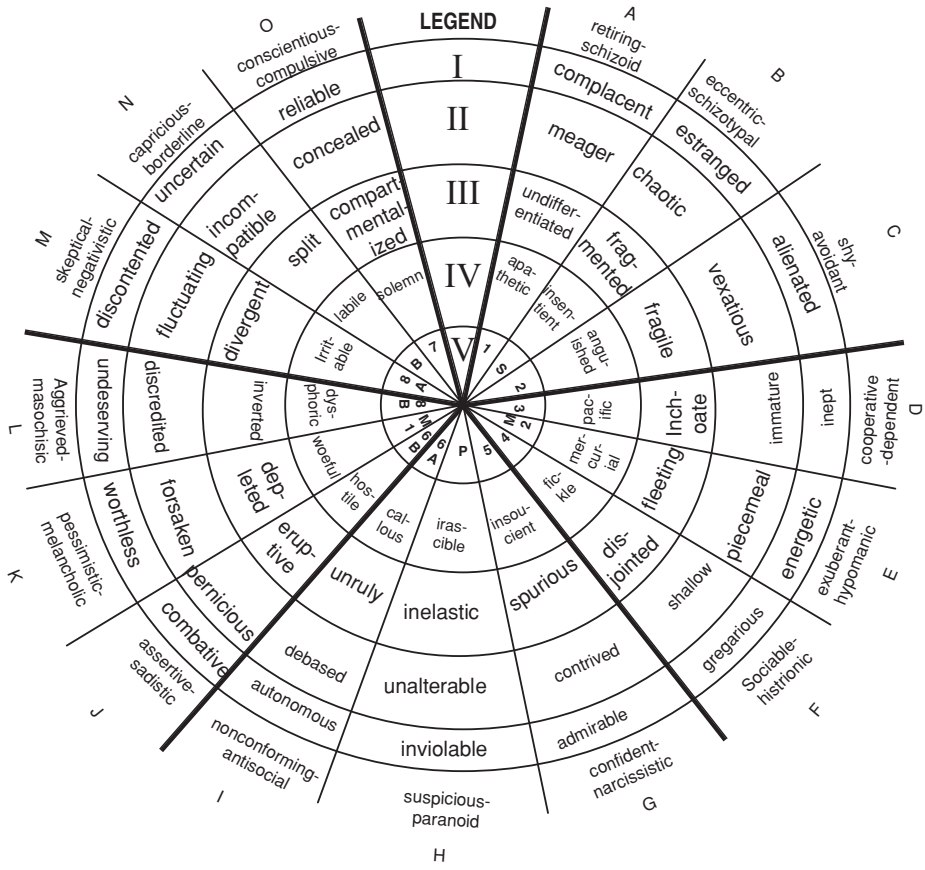

FIGURE 1.3 Personality circulargram IIB: Structural personologic domains. I: Self-Image; II: Intrapsychic Content; III: Intrapsychic Structure; IV: Mood-Affect; V: MCMI-III Scale.

Benjamin's 2005 approach) and pharmacologic medications (e.g., daily regimen of Prozac).

Several words may usefully be said regarding the newly devised MG-PDC instrument (Millon & Grossman, 2006). 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, 1986, 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 domains in Tables 1.1 through 1.8, beginning with Expressive Behavior, you will see 15 descriptive trait choices. Locate the descriptive choice that appears to you to *best fit* in characterizing the patient you are thinking about. You would fill in that choice in the 1 box 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. Fill in the 2 box, the second-best-fit column.

Should there be other listed descriptive trait features that are applicable to this person, but less so than the one selected as second best, fill in the 3 box in the third-best-fit column. You may fill in up to three boxes in the third-best-fit column. (Note that only one trait description may be marked in each of the first- and second-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

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 1st, 2nd, and 3rd best fit personality spectrum diagnosis on Table 1.9.

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 sublimatory 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.

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
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

Empirical and theoretical developments of the past decade have led to an expansion in the number of personality disorder types and subtypes in the recent and forthcoming literature. Likewise, there has been a growing interest in refining the disorders into a continuum or spectrum from normal to abnormal personalities. Toward the end of contributing further to these advances, we would like you to select, as best you can, three of the personality spectra listed in Table 1.9 that you believe may best characterize the person you have just evaluated. As before, select the 1st best fit, the 2nd best fit, and the 3rd best fit. If you wish, you may go back to review your eight "first best" choices and *double encircle* the three that you judge most important for therapeutic intervention.

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.

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 the third book in the 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

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.
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.

Source:

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 with 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 are 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 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.

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 shaken 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.