Resolving Difficult Clinical Syndromes

A Personalized Psychotherapy Approach

Theodore Millon Seth Grossman

John Wiley & Sons, Inc.
Resolving Difficult Clinical Syndromes
Other Books in the Series

*Overcoming Resistant Personality Disorders: A Personalized Psychotherapy Approach*
Theodore Millon and Seth Grossman

*Moderating Severe Personality Disorders: A Personalized Psychotherapy Approach*
Theodore Millon and Seth Grossman
Resolving Difficult Clinical Syndromes

A Personalized Psychotherapy Approach

Theodore Millon    Seth Grossman
To our patients of the past 50 years
## CONTENTS

Preface ix

**Part One**

| CHAPTER 1 | The Wisdom of Personalized Therapy | 3 |

**Part Two**

| CHAPTER 2 | Personalized Therapy of Mood-Related Syndromes: Dysthymic, Major Depressive, and Bipolar Disorders | 81 |
| CHAPTER 3 | Personalized Therapy of Acute, Posttraumatic, and Generalized Anxiety Syndromes | 115 |
| CHAPTER 4 | Personalized Therapy of Anxiety-Related Psychological Syndromes: Phobic, Dissociative, and Obsessive-Compulsive Disorders | 153 |
| CHAPTER 5 | Personalized Therapy of Anxiety-Related Physical Syndromes: Somatoform and Conversion Disorders | 191 |
## CONTENTS

### CHAPTER 6  Personalized Therapy of Cognitive Dysfunction Syndromes: Substance-Related and Schizophrenia Spectrum Disorders  
221

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>References</td>
<td>253</td>
</tr>
<tr>
<td>Index</td>
<td>265</td>
</tr>
</tbody>
</table>
Would it not be a great step forward in our field if diagnosis or psychological assessment, following a series of interviews, tests, or laboratory procedures, actually pointed clearly to what a clinician should do in therapy? Would it not be good if all evaluations could spell out which specific features of a patient’s psychological makeup are fundamentally problematic—biological, cognitive, interpersonal—and therefore deserved primary therapeutic attention? Is it not time for clinicians to recognize that diagnosis can lead directly to the course of therapy?

This diagnosis-to-therapy goal can be achieved by employing treatment-oriented assessment tools (e.g., the Millon Clinical Multiaxial Inventory III Facet Scales, the Millon-Grossman Personality Disorder Checklist).

“Personalized psychotherapy” is not a vague concept or a platitudinous buzzword in our treatment approach, but an explicit commitment to focus first and foremost on the unique composite of a patient’s psychological makeup. That focus should be followed by a precise formulation and specification of therapeutic rationales and techniques to remedy those personal attributes that are assessed as problematic.

Therapists should take cognizance of the person from the start, for the psychic parts and environmental contexts take on different meanings and call for different responses depending on the specific person to whom they are anchored. To focus on one social structure or one psychological realm of expression, without understanding its undergirding or reference base, is to engage in potentially misguided, if not random, therapeutic techniques.

Fledgling therapists should learn further that the symptoms and disorders we diagnose represent but one or another segment of a complex of organically interwoven psychological elements. The significance of each clinical feature can best be grasped by reviewing a patient’s unique psychological experiences and his or her overall psychic pattern or configurational dynamics, of which any one component is but a single part.
**Preface**

Therapies that conceptualize clinical disorders from a single perspective, be it psychodynamic, cognitive, behavioral, or physiological, may be useful, and even necessary, but are not sufficient in themselves to undertake a therapy of the patient, disordered or not. The revolution we propose asserts that clinical disorders are not exclusively behavioral or cognitive or unconscious, that is, confined to a particular expressive form. The overall pattern of a person’s traits and psychic expressions are systemic and multioperational. No part of the system exists in complete isolation from the others. Every part is directly or indirectly tied to every other, such that there is an emergent synergism that accounts for a disorder’s clinical tenacity.

Personality is real; it is a composite of intertwined elements whose totality must be reckoned with in all therapeutic enterprises. The key to treating our patients, therefore, lies in therapy that is designed to be as organismically complex as the person himself or herself; this form of therapy should generate more than the sum of its parts. Difficult as this may appear, we hope to demonstrate its ease and utility.

If our wish takes root, this book will serve as a revolutionary call, a renaissance that brings therapy back to the natural reality of patients’ lives.

It is our hope that the book will lead all of us back to reality by exploring both the unique intricacy and the wide diversity of the patients we treat. Despite frequent brilliance, most single-focus schools of therapy (e.g., behavioral, psychoanalytic) have become inbred. Of more concern, they persist in narrowing the clinicians’ attention to just one or another facet of their patients’ psychological makeup, thereby wandering ever farther from human reality. They cease to represent the full richness of their patients’ lives, considering as significant only one of several psychic spheres: the unconscious, biochemical processes, cognitive schemas, or some other. In effect, what has been taught to most fledgling therapists is an artificial reality, one that may have been formulated in its early stages as an original perspective and insightful methodology, but has drifted increasingly from its moorings over time, no longer anchored to the complex clinical reality from which it was abstracted.

How does our therapeutic approach differ from others? In essence, we come to the treatment task not with a favored theory or technique, but with the patient’s unique constellation of personality attributes given center stage. 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.

It should be noted that a parallel personalized approach to physical treatment has currently achieved recognition in what is called genomic medicine. Here medical scientists have begun to tinker with 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.
As detailed in the first chapter of this first book of this *Personalized Psychotherapy* series, *Resolving Difficult Clinical Syndromes*, we have formulated eight personality components or domains comprising what we might 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 styles and pathology (e.g., avoidant style, 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 become 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).

In this first book of the personalized series, we attempt to show that all the clinical syndromes that constitute Axis I can be understood more clearly and treated more effectively when conceived as an outgrowth of a patient's overall personality style. To say that depression is experienced and expressed differently from one patient to the next is a truism; so general a statement, however, will not suffice for a book such as this. Our task requires much more.

This first book focuses on resolving difficult clinical syndromes of Axis I of the *Diagnostic and Statistical Manual of Mental Disorders*; it provides extensive information and illustrations on how patients with different personality vulnerabilities react to and cope with life's stressors. With this body of knowledge in hand, therapists should be guided to undertake more precise and effective treatment plans. For example, a dependent person will often respond to a divorce situation with feelings of helplessness and hopelessness, whereas a narcissist faced with similar circumstances may respond in a disdainful and cavalier way. Even when both a dependent and a narcissist exhibit depressive symptoms in common, the precipitant of these symptoms will likely have been quite different; furthermore, treatment—its goals and methods—should likewise differ. In effect, similar symptoms do not call for the same treatment if the pattern of patient vulnerabilities and coping styles differ. In the case of dependents, the emotional turmoil may arise from their feelings of lower self-esteem and their inability to function autonomously; in narcissists, depression may be the outcropping of failed cognitive denials as well as a consequent collapse of their habitual interpersonal arrogance.

Whether we work with a clinical syndrome's “part functions” as expressed in behavior (social isolation), or cognitions (a delusional belief), or affect (depression), or a biological defect (appetite loss) or we address contextual systems that focus on the larger environment, the family, or the group, or the socioeconomic and political conditions of life, the crossover point, the place that links the varieties of clinical expression to the individual's social context, is the person. The person is the intersecting medium that brings functions and systems together. Persons, however, are more than just crossover mediums. As we elaborate in this first book of the series on resolving difficult clinical syndromes, they are the only organically integrated system in the psychological domain, inherently created from birth as natural entities. Moreover, it is the
PREFACE

person who lies at the heart of the therapeutic experience, the substantive being who gives meaning and coherence to symptoms and traits—be they behaviors, affects, or mechanisms—as well as that being, that singular entity, who gives life and expression to family interactions and social processes.

Looking at a patient’s totality can present a bewildering if not chaotic array of therapeutic possibilities, potentially driving even the most motivated young clinician to back off into a more manageable and simpler worldview, be it cognitive or pharmacologic. But as we contend here, complexity need not be experienced as overwhelming; nor does it mean chaos, if we can create a logic and order to the treatment plan. We try to provide logic and order by illustrating that the systematic integration of an Axis I syndrome into its foundation in an Axis II disorder is not only feasible, but is one that is conducive to both briefer and more effective therapy. We should note, however, that a therapeutic method, no matter how logical and rational it may be, can never achieve the precision of the physical sciences. In our field we must be ever alert to the many subtle variations and sequences, as well as the constantly evolving forces, that compose the natural course of human life.

THEODORE MILLON
SETH D. GROSSMAN

Coral Gables, Florida
PART ONE
The Wisdom of Personalized Therapy

Introduction

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

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

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

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

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

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

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

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

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

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

Reflections on Psychotherapeutic Practice Today

As we look back over the long course of scientific history we see patterns of progress and regress, brilliant leaps alternating with foolish pursuits and blind stumblings.
Significant discoveries often were made by capitalizing on accidental observation; at other times, progress required the clearing away of deeply entrenched but erroneous beliefs.

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

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

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

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

The varied settings, goals, processes, and orientation that differentiate psychological treatment methods may lead one to conclude that the field of psychotherapy comprises a motley assemblage of techniques. However, despite substantive differences in verbalized
rationales and technical procedures, psychotherapies sound more dissimilar than they are in practice. Close inspection reveals that the aims of many are fundamentally alike and that their methods, although focusing on different facets or levels of psychological functioning, deal essentially with similar pathological processes.

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

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

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

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