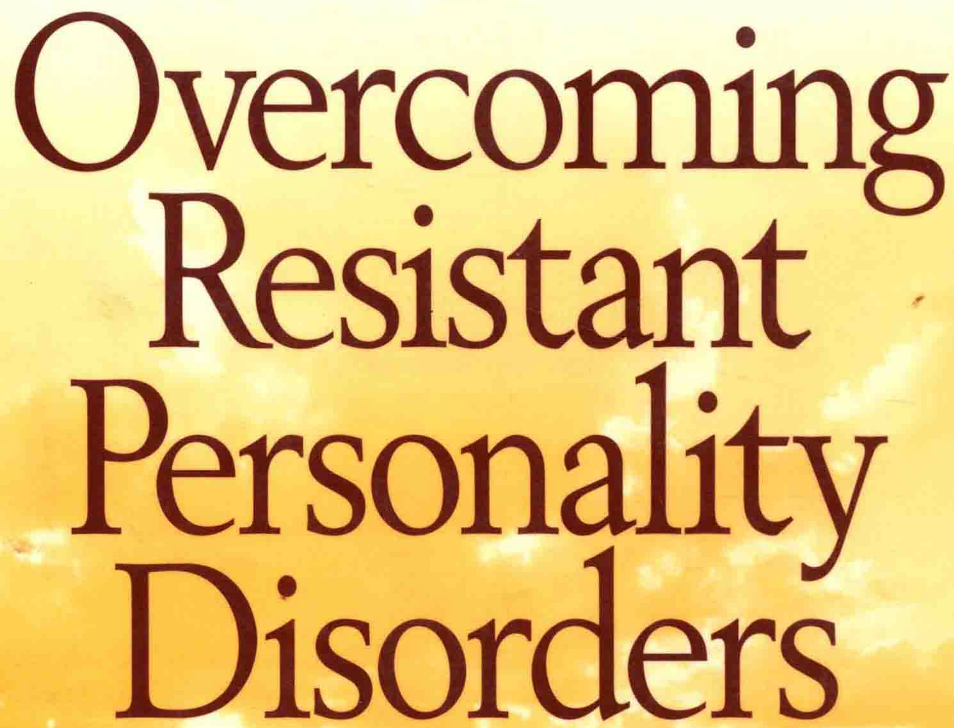

Overcoming Resistant Personality Disorders

A Personalized Psychotherapy Approach

Theodore Millon Seth Grossman

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Overcoming Resistant Personality Disorders

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Resolving Difficult Clinical Syndromes: A Personalized Psychotherapy Approach
Theodore Millon and Seth Grossman

Moderating Severe Personality Disorders: A Personalized Psychotherapy Approach
Theodore Millon and Seth Grossman

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To our patients of the past 50 years

PREFACE

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 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.

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 the first book of this *Personalized Psychotherapy* series, 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 the 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.

The 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 the first book of the series, they are the only organically integrated system in the psychological domain, inherently created from birth as natural entities. Moreover, it is the 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.

We are pleased to report that an excellent 240-minute videotape entitled "*DSM-IV* Personality Disorders: The Subtypes" has been produced and is distributed by Insight Media (800-233-9910, www.Insight-Media.com), psychology's premier publisher of videos and CD-Roms. It is available for purchase by instructors and clinicians who wish to view over 60 case vignettes that illustrate all *DSM-IV* personality prototypes and subtypes, as interviewed by psychologists and discussed by the senior author of this book.

THEODORE MILLON
SETH D. GROSSMAN

Coral Gables, Florida

CONTENTS

Preface ix

Part One

CHAPTER 1 **Personalized Psychotherapy:** A Recapitulation 3

Part Two

CHAPTER 2 **Personalized Therapy for the Needy/Dependent Personality Patterns** 51

CHAPTER 3 **Personalized Therapy for the Sociable/Histrionic Personality Patterns** 89

CHAPTER 4 **Personalized Therapy for the Confident/Narcissistic Personality Patterns** 129

CHAPTER 5 **Personalized Therapy for the Nonconforming/ Antisocial Personality Patterns** 165

CHAPTER 6 **Personalized Therapy for the Assertive/Sadistic Personality Patterns** 201

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CHAPTER 7 Personalized Therapy for the Conscientious/Compulsive Personality Patterns 235

CHAPTER 8 Personalized Therapy for the Skeptical/Negativistic Personality Patterns 275

References 313

Index 331

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 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.

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