MCMI-III™

MILLON™ CLINICAL
MULTIAXIAL INVENTORY–III

MCMI-III™
Millon™ Clinical Multiaxial Inventory-III
Interpretive Report with Grossman Facet Scales

Theodore Millon, PhD, DSc

Name:	Sample Interpretive Report
ID Number:	98765
Age:	22
Gender:	Female
Setting:	Outpatient Never Hospitalized
Race:	White
Marital Status:	Never Married
Date Assessed:	04/03/2009

PEARSON

PsychCorp

[7.0 / 85 / 2.3.17]

CAPSULE SUMMARY

MCMI-III reports are normed on patients who were in the early phases of assessment or psychotherapy for emotional discomfort or social difficulties. Respondents who do not fit this normative population or who have inappropriately taken the MCMI-III for nonclinical purposes may have inaccurate reports. The MCMI-III report cannot be considered definitive. It should be evaluated in conjunction with additional clinical data. The report should be evaluated by a mental health clinician trained in the use of psychological tests. The report should not be shown to patients or their relatives.

Interpretive Considerations
The client is a 22-year-old single white female with 11 years of education. She is currently being seen as an outpatient, and she reports that she has recently experienced problems that involve her job or school and use of alcohol. These self-reported difficulties, which have occurred for an undetermined period of time, may take the form of an Axis I disorder.

Unless this patient is a well-functioning adult with only minor life stressors, her responses suggest a need for social approval or naivete about psychological matters. This interpretive report should be read with these characteristics in mind.

Profile Severity
On the basis of the test data, it may be reasonable to assume that the patient is experiencing a moderately severe mental disorder; further professional study may be advisable to assess the need for ongoing clinical care. The text of the following interpretive report may need to be modulated only slightly upward or downward given this probable level of severity.

Possible Diagnoses
She appears to fit the following Axis II classifications best: Antisocial Personality Disorder, with Histrionic Personality Features, and Paranoid Personality Features.

Axis I clinical syndromes are suggested by the client's MCMI-III profile in the areas of Alcohol Abuse and Psychoactive Substance Abuse NOS.

Therapeutic Considerations
Superficially gregarious and friendly, this patient can readily become ill-humored and touchy if subjected to persistent social discomfort and external demands. She is disinclined to persevere in routine tasks such as long-term therapeutic compliance, but there may be considerable gain by using short-term treatment regimens that focus on specific goals and time-limited techniques.

MILLON CLINICAL MULTIAXIAL INVENTORY - III

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INVALIDITY (SCALE V) = 0 INCONSISTENCY (SCALE W) = 4
PERSONALITY CODE: 6A ** - * 4 5 6B 8A 8B 3 + 7 2A " 1 2B ' ' // - ** - * //
SYNDROME CODE: B ** T * // - ** - * //
DEMOGRAPHIC CODE: 98765/ON/F/22/W/N/11/JO/AL/------/10/------/

CATEGORY		SCORE RAW	SCORE BR	PROFILE OF BR SCORES 0 60 75 85 115	DIAGNOSTIC SCALES
MODIFYING INDICES	X	92	56		DISCLOSURE
	Y	17	75		DESIRABILITY
	Z	4	40		DEBASEMENT
CLINICAL PERSONALITY PATTERNS	1	2	24		SCHIZOID
	2A	3	36		AVOIDANT
	2B	1	10		DEPRESSIVE
	3	6	60		DEPENDENT
	4	20	72		HISTRIONIC
	5	15	67		NARCISSISTIC
	6A	17	92		ANTISOCIAL
	6B	8	66		SADISTIC
	7	12	45		COMPULSIVE
	8A	9	66		NEGATIVISTIC
	8B	4	63		MASOCHISTIC
SEVERE PERSONALITY PATHOLOGY	S	4	62		SCHIZOTYPAL
	C	5	60		BORDERLINE
	P	9	67		PARANOID
CLINICAL SYNDROMES	A	1	20		ANXIETY
	H	0	0		SOMATOFORM
	N	7	66		BIPOLAR: MANIC
	D	4	48		DYSTHYMIA
	B	12	88		ALCOHOL DEPENDENCE
	T	11	79		DRUG DEPENDENCE
	R	0	0		POST-TRAUMATIC STRESS
SEVERE CLINICAL SYNDROMES	SS	1	15		THOUGHT DISORDER
	CC	0	0		MAJOR DEPRESSION
	PP	4	65		DELUSIONAL DISORDER

MILLON CLINICAL MULTIAXIAL INVENTORY - III

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FACET SCORES FOR HIGHEST PERSONALITY SCALES BR 65 OR HIGHER

HIGHEST PERSONALITY SCALE BR 65 OR HIGHER: SCALE 6A Antisocial

SCALE	SCORE RAW	SCORE BR	PROFILE OF BR SCORES 0 60 70 80 90 100	FACET SCALES
6A.1	4	70		Expressively Impulsive
6A.2	8	98		Acting-Out Mechanism
6A.3	2	68		Interpersonally Irresponsible

SECOND-HIGHEST PERSONALITY SCALE BR 65 OR HIGHER: SCALE 4 Histrionic

SCALE	SCORE RAW	SCORE BR	PROFILE OF BR SCORES 0 60 70 80 90 100	FACET SCALES
4.1	7	100		Gregarious Self-Image
4.2	5	65		Interpersonally Attention-Seeking
4.3	5	81		Expressively Dramatic

THIRD-HIGHEST PERSONALITY SCALE BR 65 OR HIGHER: SCALE P Paranoid

SCALE	SCORE RAW	SCORE BR	PROFILE OF BR SCORES 0 60 70 80 90 100	FACET SCALES
P.1	3	87		Cognitively Mistrustful
P.2	1	55		Expressively Defensive
P.3	3	76		Projection Mechanism

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COMPLETE LISTING OF MCMI-III GROSSMAN FACET SCALE SCORES

		RAW	BR
1	**Schizoid**		
1.1	Temperamentally Apathetic	0	0
1.2	Interpersonally Unengaged	1	27
1.3	Expressively Impassive	2	47
2A	**Avoidant**		
2A.1	Interpersonally Aversive	1	42
2A.2	Alienated Self-Image	1	37
2A.3	Vexatious Representations	0	0
2B	**Depressive**		
2B.1	Temperamentally Woeful	0	0
2B.2	Worthless Self-Image	2	54
2B.3	Cognitively Fatalistic	0	0
3	**Dependent**		
3.1	Inept Self-Image	3	61
3.2	Interpersonally Submissive	3	53
3.3	Immature Representations	0	0
4	**Histrionic**		
4.1	Gregarious Self-Image	7	100
4.2	Interpersonally Attention-Seeking	5	65
4.3	Expressively Dramatic	5	81
5	**Narcissistic**		
5.1	Admirable Self-Image	7	76
5.2	Cognitively Expansive	2	59
5.3	Interpersonally Exploitive	1	51
6A	**Antisocial**		
6A.1	Expressively Impulsive	4	70
6A.2	Acting-Out Mechanism	8	98
6A.3	Interpersonally Irresponsible	2	68

		RAW	BR
6B	**Sadistic**		
6B.1	Temperamentally Hostile	2	61
6B.2	Eruptive Organization	5	91
6B.3	Pernicious Representations	3	72
7	**Compulsive**		
7.1	Cognitively Constricted	6	69
7.2	Interpersonally Respectful	4	66
7.3	Reliable Self-Image	1	6
8A	**Negativistic**		
8A.1	Temperamentally Irritable	3	53
8A.2	Expressively Resentful	2	64
8A.3	Discontented Self-Image	2	55
8B	**Masochistic**		
8B.1	Discredited Representations	1	52
8B.2	Cognitively Diffident	4	71
8B.3	Undeserving Self-Image	1	43
S	**Schizotypal**		
S.1	Estranged Self-Image	4	75
S.2	Cognitively Autistic	0	0
S.3	Chaotic Representations	0	0
C	**Borderline**		
C.1	Temperamentally Labile	0	0
C.2	Interpersonally Paradoxical	5	84
C.3	Uncertain Self-Image	1	46
P	**Paranoid**		
P.1	Cognitively Mistrustful	3	87
P.2	Expressively Defensive	1	55
P.3	Projection Mechanism	3	76

For each of the Clinical Personality Patterns and Severe Personality Pathology scales (the scale names shown in **bold**), scores on the three facet scales are shown beneath the scale name.

RESPONSE TENDENCIES

Unless this patient is a demonstrably well-functioning adult who is currently facing minor life stressors, her responses suggest (1) a well-established need for social approval and commendation, evident in tendencies to present herself in a favorable light, or (2) a general naivete about psychological matters, including a possible deficit in self-knowledge. The interpretation of this profile should be made with these characteristics in mind.

No adjustments were made to the BR scores of this individual to account for any undesirable response tendencies.

AXIS II: PERSONALITY PATTERNS

The following paragraphs refer to those enduring and pervasive personality traits that underlie this woman's emotional, cognitive, and interpersonal difficulties. Rather than focus on the largely transitory symptoms that make up Axis I clinical syndromes, this section concentrates on her more habitual and maladaptive methods of relating, behaving, thinking, and feeling.

The MCMI-III profile of this woman suggests a veneer of friendliness and sociability overlying a deeper contempt for conventional morals. Although she is able to make a good impression on casual acquaintances, there is a characteristic unreliability, impulsiveness, restlessness, and moodiness that may be seen frequently by family members and close associates. There is the possibility that she is untrustworthy and unreliable, persistently seeking attention and excitement and often engaging in seductive and self-dramatizing behavior. Her relationships may be shallow and fleeting, and she may fail to meet routine responsibilities. Interactions may be disrupted by caustic comments and hostile outbursts. Not infrequently, she may act impetuously with insufficient deliberation and poor judgment. She also tends to exhibit short-lived enthusiasm followed by disillusionment and resentment at having been misled. The referring clinician may wish to corroborate these hypotheses as well as those in subsequent paragraphs.

This woman is unlikely to admit responsibility for personal or family difficulties, possessing what may be an easily circumvented conscience. Moreover, she may be quite facile in denying the presence of psychological tension or conflicts. Interpersonal problems are likely to be rationalized, especially those that she engenders, and blame may readily be projected onto others. Although she is prone to be self-indulgent and insistent on gaining the center of attention, she may reciprocate this attention with only minimal loyalty and affection.

When her actions are criticized or she is subjected to minor pressures or faced with potential embarrassment, she may be inclined to abandon her responsibilities, possibly with minimal guilt or remorse. Unfettered by the restrictions of social conventions or the restraints of personal loyalties, she may be quick to free herself from unwanted obligations. Her superficial affability may easily collapse, and she may be readily inclined to jettison anyone who might undermine her autonomy. Although infrequent, her temper outbursts may turn into uncontrollable rages. More typically, she is impetuous and imprudent, driven by a need for excitement and an inability to delay gratification, with minimal regard for consequences. Stimulus-seeking, she may restlessly chase one capricious whim after another, and she may have traveled an erratic course of irresponsibility, perhaps even delighting in defying social

conventions. She appears to have a poor prognosis for staying out of trouble.

GROSSMAN PERSONALITY FACET SCALES

The Grossman facet scales are designed to aid in the interpretation of elevations on the Clinical Personality Patterns and Severe Personality Pathology scales by helping to pinpoint the specific personality processes (e.g., self-image, interpersonal relations) that underlie overall scale elevations. A careful analysis of this patient's facet scale scores suggests that the following characteristics are among her most prominent personality features.

Most notable is her view of herself as a socially stimulating and charming person, one who seeks to pursue a busy and pleasure-oriented lifestyle and is invariably perceived by others as appealing and attractive. She probably lacks insight, however, failing to recognize, or to admit recognizing, her deeper insecurities and her desperate need to garner attention and to be well liked. Signs of inner turmoil, weakness, depression, or hostility are almost invariably denied, suppressed so as not to be part of her sense of self.

Also salient are her failure to constrain or postpone the expression of offensive thoughts or malevolent actions, a deficit in guilt feelings, and a consequent disinclination to refashion repugnant impulses in sublimated form. Given her perception of the environment, she does not feel the need to rationalize her outbursts, which she believes are fully justified as a response to the supposed malevolence of others. She experiences herself as the victim, an indignant bystander subjected to persecution and hostility. Through this intrapsychic maneuver, she not only disowns her malicious impulses but attributes the evil to others. As a persecuted victim, she feels free to counterattack and gain restitution and vindication.

Also worthy of attention are her suspiciousness regarding the motives of others and her tendency to misconstrue innocuous events as signifying proof of duplicity or conspiratorial intent. Her learned feelings and attitudes have produced deep mistrust and pervasive suspiciousness of others. She is notoriously oversensitive and disposed to detect signs of trickery and deception everywhere. She is preoccupied with these thoughts, actively picking up minute cues, then magnifying and distorting them so as to confirm her worst expectations. To further complicate matters, events that fail to confirm her suspicions are evidence in her mind of just how deceitful and clever others can be.

Early treatment efforts are likely to produce optimal results if they are oriented toward modifying the personality features just described.

AXIS I: CLINICAL SYNDROMES

The features and dynamics of the following Axis I clinical syndromes appear worthy of description and analysis. They may arise in response to external precipitants but are likely to reflect and accentuate several of the more enduring and pervasive aspects of this woman's basic personality makeup.

The evidence is strong that this woman exhibits an alcoholic disorder, probably contained within the context of a pervasive substance-abuse syndrome. Her excessive drinking may also be seen, as well as understood, within the context of a broad-based, somewhat self-indulgent, and excitement-seeking

lifestyle. Hedonistic and manipulative, she may use alcohol to maintain the camaraderie of youthful socializing. In addition to accommodating her immature, pleasure-oriented, and exploitive traits, alcoholism permits her to express a number of narcissistic attitudes, antiauthority resentments, an unwillingness to tolerate the limits of conventional society, and rejection of traditional family constraints.

An addictive disposition, probably involving active use of illicit or street agents, seems highly probable in this woman, who is hedonistic and exploitive. That drug use fits her recreational pattern of adolescent-like stimulus seeking and narcissistic indulgence is likely. Also consonant with her personality is the use of drugs as a symbol of disdain for conventional social values as well as an image of flouting authority that includes the posturing of independence from her family.

NOTEWORTHY RESPONSES

The client answered the following statements in the direction noted in parentheses. These items suggest specific problem areas that the clinician may wish to investigate.

Health Preoccupation
No items endorsed.

Interpersonal Alienation
48. Omitted Item (True)
63. Omitted Item (True)

Emotional Dyscontrol
14. Omitted Item (True)

Self-Destructive Potential
24. Omitted Item (True)

Childhood Abuse
No items endorsed.

Eating Disorder
No items endorsed.

Special Note:
The content of the test items is included in the actual reports. To protect the integrity of the test, the item content does not appear in this sample report.

POSSIBLE *DSM-IV*® MULTIAXIAL DIAGNOSES

The following diagnostic assignments should be considered judgments of personality and clinical prototypes that correspond conceptually to formal diagnostic categories. The diagnostic criteria and items used in the MCMI-III differ somewhat from those in the *DSM-IV*, but there are sufficient parallels in the MCMI-III items to recommend consideration of the following assignments. It should be noted that several *DSM-IV* Axis I syndromes are not assessed in the MCMI-III. Definitive diagnoses must draw on biographical, observational, and interview data in addition to self-report inventories such as the MCMI-III.

Axis I: Clinical Syndrome
The major complaints and behaviors of the patient parallel the following Axis I diagnoses, listed in order of their clinical significance and salience.

305.00 Alcohol Abuse
305.90 Psychoactive Substance Abuse NOS

Axis II: Personality Disorders
Deeply ingrained and pervasive patterns of maladaptive functioning underlie Axis I clinical syndromal pictures. The following personality prototypes correspond to the most probable *DSM-IV* diagnoses (Disorders, Traits, Features) that characterize this patient.

Personality configuration composed of the following:

301.70 Antisocial Personality Disorder
with Histrionic Personality Features
and Paranoid Personality Features

Course: The major personality features described previously reflect long-term or chronic traits that are likely to have persisted for several years prior to the present assessment.
The clinical syndromes described previously tend to be relatively transient, waxing and waning in their prominence and intensity depending on the presence of environmental stress.

Axis IV: Psychosocial and Environmental Problems
In completing the MCMI-III, this individual identified the following problems that may be complicating or exacerbating her present emotional state. They are listed in order of importance as indicated by the client. This information should be viewed as a guide for further investigation by the clinician.

Job or School Problems; Use of Alcohol

TREATMENT GUIDE

If additional clinical data are supportive of the MCMI-III's hypotheses, it is likely that this patient's difficulties can be managed with either brief or extended therapeutic methods. The following guide to treatment planning is oriented toward issues and techniques of a short-term character, focusing on matters that might call for immediate attention, followed by time-limited procedures designed to reduce the likelihood of repeated relapses.

Worthy of note is the possibility of a troublesome alcohol and/or substance-abuse disorder. If verified, appropriate short-term behavioral management or group therapy programs should be rapidly implemented.

Once this patient's more pressing or acute difficulties are adequately stabilized, attention should be directed toward goals that would aid in preventing a recurrence of problems, focusing on circumscribed issues and employing delimited methods such as those discussed in the following paragraphs.

Essential to the success of a short-term approach with this woman is the therapist's readiness to see things from the patient's point of view and to convey a sense of trust and to create a feeling of alliance. To achieve reasonable short-term goals, this building of rapport must not be interpreted as a sign of the therapist's capitulation to the patient's bluff and arrogance. Brief treatment with her will require a balance of professional firmness and authority, mixed with tolerance for the patient's less attractive traits. By building an image of a fair-minded and strong authority figure, the therapist may successfully employ cognitive methods that will encourage the patient to change her expectations. Through reasoned and convincing comments, the therapist may provide a model for the patient to learn the mix of power, logic and fairness.

Less confrontive cognitive approaches may provide the patient with opportunities to vent her anger, even in short-term therapy. Once drained of these hostile feelings, she may be led to examine her habitual behavior and cognitive attitudes and be guided into less destructive perceptions and outlets than before. Interpersonal methods, such as those of Benjamin and Kiesler, may provide a means to explore more socially acceptable behaviors. As far as group methods are concerned, until the patient has incorporated changed cognitions and actions, she may intrude and disrupt therapeutic functions. On the other hand, she may become a useful catalyst for short-term group interaction and gain some useful insights and a few constructive skills.

A useful short-term goal for this woman is to enable her to tolerate the experience of guilt or to accept blame for the turmoil she may cause. Cognitive methods using a measure of confrontation may help undermine her tendency to always trace problems to another person's stupidity, laziness, or hostility. When she does accept responsibility for some of her difficulties it is important that the therapist be prepared to deal with the patient's inclination to resent the therapist for supposedly tricking her into admitting it. Similarly, the therapist should be ready to be challenged and avoid efforts to outwit her. The patient may try to set up situations to test the therapist's skills, to catch inconsistencies, to arouse ire and, if possible, to belittle and humiliate the therapist. Restraining impulses to express condemning attitudes can be a major task for the therapist, but one that can be used for positive gains, especially if tied into the application of combined cognitive (e.g., Beck, Ellis) and interpersonal interventions.

It should be noted that the precipitant for this woman's treatment is probably situational rather than internal. Hence, she is unlikely to have sought therapy voluntarily, and she may be convinced that if she were just left alone, she could work matters out on her own. Such beliefs will have to be confronted, albeit carefully. Similarly, if treatment is self-motivated, it probably was inspired by a series of legal entanglements, family problems, social humiliations, or achievement failures. Whatever its source, a firm cognitive and behavior-change approach would seem required. For this domineering and often intimidating woman, complaints are likely to be expressed in the form of irritability and restlessness. To succeed in her initial disinclination to be frank with authority figures, she may wander from one superficial topic to another. This inclination should be monitored and prevented. Moreover, contact with family members may be advisable because they may report matters quite differently than the patient. To ensure that she takes discussions seriously, she may have to be confronted directly with evidence of her contribution to her troubles. Treatment is best geared to short-term goals, reestablishing her psychic balance, and strengthening her previously adequate coping behavior with cognitive methods, unless her actions are frankly antisocial. In general, short-term approaches with this patient are best directed toward building controls rather than insights, toward the here and now rather than the past, and toward teaching her ways to sustain relationships cooperatively rather than with dominance and intimidation.

End of Report

ITEM RESPONSES

1: 2	2: 1	3: 1	4: 2	5: 2	6: 1	7: 1	8: 1	9: 2	10: 2
11: 2	12: 2	13: 1	14: 1	15: 2	16: 1	17: 1	18: 2	19: 2	20: 2
21: 1	22: 2	23: 2	24: 1	25: 2	26: 2	27: 2	28: 2	29: 2	30: 2
31: 2	32: 1	33: 2	34: 2	35: 2	36: 2	37: 2	38: 2	39: 2	40: 1
41: 1	42: 2	43: 2	44: 2	45: 1	46: 2	47: 2	48: 1	49: 1	50: 2
51: 1	52: 1	53: 2	54: 1	55: 2	56: 1	57: 1	58: 2	59: 1	60: 1
61: 2	62: 2	63: 1	64: 2	65: 2	66: 1	67: 1	68: 2	69: 2	70: 2
71: 2	72: 2	73: 2	74: 2	75: 2	76: 2	77: 2	78: 2	79: 2	80: 1
81: 2	82: 2	83: 2	84: 2	85: 2	86: 2	87: 2	88: 1	89: 2	90: 2
91: 2	92: 2	93: 2	94: 2	95: 2	96: 2	97: 1	98: 2	99: 2	100: 2
101: 1	102: 2	103: 2	104: 2	105: 2	106: 2	107: 2	108: 2	109: 2	110: 2
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151: 2	152: 2	153: 2	154: 2	155: 2	156: 2	157: 2	158: 2	159: 2	160: 2
161: 2	162: 2	163: 2	164: 2	165: 2	166: 1	167: 2	168: 2	169: 2	170: 2
171: 2	172: 2	173: 2	174: 2	175: 2					