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Millon Clinical Multiaxial Inventory-III (MCMI-III)

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INTRODUCTION

The Millon Clinical Multiaxial Inventory (MCMI) is a useful instrument for the assessment of personality disorders and clinical syndromes. A recent survey on psychological test usage indicated that the MCMI is among the 25 most frequently used psychological tests in clinical practice and that the MCMI is ranked third, behind only the MMPI and the Rorschach, in terms of research studies on the test published within the past five years. However, although there is now a substantial clinical and research base with this test, laments continue to be heard concerning the difficulties in interpreting it. Therefore, an objective presentation of interpretive principles is now warranted.

This chapter presents interpretive principles for using the MCMI-III. First, the theory on which the MCMI-III is based will be presented, followed by Millon's domain-oriented approach to understanding personality disorder prototypes. Next, issues of administration and scoring are presented, followed by principles of interpretation which are then illustrated by a detailed case presentation. The chapter concludes with a discussion of computer-based interpretation of this test.

THEORETICAL UNDERPINNINGS

Millon argues that the structure of a clinical science contains four elements: (a) a *theory* to explain and understand the observed phenomena. Theory is then used to test hypotheses derived from the theory, (b) a *taxonomy* which classifies the observed phenomena and which is derived from the theory itself, (c) *instrumentation* which measures, quantifies, or assesses

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this phenomena, and (d) *intervention*, which includes techniques and strategies for remediation or amelioration of those phenomena which appear outside the normal range.

All of the Millon inventories (e.g., the *Millon Clinical Multiaxial Inventory [MCMI-III]*, the *Millon Adolescent Clinical Inventory [MACI]*, the *Millon Behavioral Health Inventory [MBHI]*, and the *Millon Index of Personality Styles* emanate from Millon's bioevolutionary theory. This theory posits that three personologic (personology—a phrase originally coined by Harvard psychologist Henry Murray—is the phrase used by Millon to describe the study of personality) polarities exist both in the physical world and in the psychological realm. These polarities are *Survival Aims*, *Adaptive Modes*, and *Replication Strategies*. At the biological level, organisms need to survive, adapt to their surroundings, and reproduce species of their own kind. At the psychological level, our first task also is to survive, but how we choose to survive eventuates into one aspect of our personality functioning, in that we can engage in behaviors that allow us to merely survive (e.g., avoid pain), or we can engage in behaviors that enhance our lives (e.g., seek pleasure). In adapting to an environment, we can do so actively, by changing our environment, or passively, by reacting to our environment. Finally, the psychological extension of the replication strategy can be oriented primarily toward seeking reinforcement from our own achievements (i.e., self-focused) or by seeking reinforcements by nurturing and caring for others (i.e., other-focused).

How we seek reinforcement (an adaptation strategy) is contrasted with where we seek reinforcement (a replication strategy). Millon identified five types of "personality sources of reinforcement": (1) Independent (primarily from self), (2) Dependent (primarily from others), (3) Ambivalent (self-other conflict), (4) Discordant (pain and pleasure is reversed as to reinforcement), and (5) Detached (no pleasure from either self or others). When the five sources of reinforcement are combined with two modes of adaptation, his theory derives ten basic personality patterns or styles and three severe personality disorder variants.

Within the active adaptive mode, the Independent style is called "unruly," the Dependent style is called "sociable," the Ambivalent style is called "sensitive," the Discordant style is called "forceful," and the Detached style is called "inhibited." Within the passive adaptive mode, the Independent style is called "confident," the Dependent style is called "cooperative," the Ambivalent style is called "respectful," the Discordant style is called "defeatist," and the Detached style is called "introversive."

Next, Millon argues that personality exists on a continuum. While normality may be said to reflect a balance of the three polarities (survival, adaptation, and replication), personality disorders are merely extensions of the basic personality style developed in association with compromised biology, learning histories, and environmental stresses. Millon's matrix of personality disorders also derives from his theory. Along the active adaptational mode, the Independent style at the level of disorder is called "antisocial," the Dependent style is called "histrionic," the Ambivalent style is called "negativistic," the Discordant style is called "aggressive" (sadistic), and the Detached style is called "Avoidant." Along the passive adaptational polarity, the Independent Style is called "narcissistic," the Dependent style is called "Dependent," the Ambivalent style is called "compulsive," the Discordant style is called "self-defeating (masochistic)," and the Detached style is called "schizoid."

There are also variations of severe dysfunction that represent the more severe personality disorders. The paranoid disorder can emanate from any of the five basic styles, except the Discordant type; the borderline disorder can emanate any style except from the Detached type; the schizotypal emanates from the Detached style.

Thus at the normal end the Active Dependent type is called "sociable," whereas at the pathological end this type is called "histrionic." At the normal end the Active Independent

type is called "unruly," but at the pathological end it is called "antisocial." At the normal end, the Passive Ambivalent type is called "respectful" whereas at the pathological end it is called "Compulsive". If you consider yourself primarily a cooperative person, cordial and compromising in interpersonal relations, agreeable, disinclined to become upset when stressed, and focused primarily on adapting your wishes to conform with the wishes of others, Millon's theory would type you as a Passive Dependent type, whereas if this style lead to interpersonal problems and was more exaggerated in nature, this Passive-Dependent style would be diagnosed as a dependent personality disorder.

Millon's theory-derived personality types and disorders are similar to but not exactly identical to, DSM-IV classification. In fact, Millon has two personality disorder types (aggressive/sadistic and self-defeating) that do not appear in DSM-IV. While he made efforts to bring his classification more in line that in DSM-IV, he was also insistent that his theory need not be isomorphic with the "official" classification of personalty disorders. Believing that his theory derives these personality disorders "in nature," he has elected to retain them in his theory, in his taxonomy, and in his instrumentation.

I have presented Millon's theory in its basic form, but it is far more complex and detailed than is the material provided herein. The interested reader is referred to the Suggested Readings list for more advanced treatments.

PERSONALITY DESCRIPTION

Millon refers to personality prototypes in that his theory discusses a particular style in its purest form. However, in actuality, an individual probably would not be perfectly aligned with only one style and would have both admixtures and patterns associated with two or three of the basic patterns.

In developing a system with which to describe personality prototypes, Millon employed a clinical-domain-criteria approach, emphasizing functional criteria, which are dynamic processes that are used to manage interpersonal relationships, and structural criteria, which are stable internal personality characteristics. There are four essential domains to describe each personality prototype. In the *behavioral domain*, there are expressive acts (a functional attribute), which are observable behaviors of the person, and this is interpersonal conduct (a functional attribute) or style in relating to others. At the *phenomenological domain* there are cognitive styles (a functional attribute) which would describe how a person thinks, perceives, processes information, etc., and object representations (a structural attribute), or the residue imprinted in conscious and unconscious memory which acts as a substrate for how we perceive and relate to others; there is also self-image (a structural attribute), which pertains to how a one thinks about oneself and then displays that perception to others. At the *intrapsychic domain* there are regulatory mechanisms (a functional attribute) which represent unconscious processes, and morphologic organization (a structural attribute), which represents the overall configuration of personality related to psychic boundaries, internal conflicts, the interplay of the id-ego-superego intrapsychic system, etc. Finally, there is the *biophysical domain*, of which mood or temperament is the only structural attribute. This domain pertains to how mood and temperament affect one's functioning.

Each personality disorder can thus be described according to its expressive acts, interpersonal conduct, cognitive style, object representations, self-image, regulatory mechanisms, its morphological organization, and mood or temperament. For a comprehensive report on how the personality disorders are described from this model, the reader is referred to the Suggested

Readings Section. While one can still use the MCMI-III without knowing the theory underlying its development, it is important to recognize that the MCMI-III is a theory-derived test.

The last of Millon's elements of a clinical science pertains to interventions or what is commonly referred to as psychotherapy. Millon is presently at work on a text that will provide his ideas of psychotherapy using domain-oriented techniques, polarity-oriented goals, and personality-oriented integrative strategies, but these are beyond the scope of this chapter.

TEST CONSTRUCTION AND DEVELOPMENT

In developing what eventually became the MCMI (I/II/III), Millon employed a sequential validation strategy originally suggested by Jane Loevinger. In this strategy, test validation proceeds in three phases: theoretical-substantive, internal-structural, and external-criterion.

In the theoretical-substantive phase of test construction and validation, items are evaluated on how well their content conforms to the theory from which they were derived. Millon selected items that represented not only the "official" classification system (i.e., DSM), but also developed items that derived from his theory. For example, the antisocial personality disorder, according to his theoretical model, is referred to as the Active-Independent type. Hence, there is an item on the MCMI-III as follows: " If my family puts pressure on me, I'm likely to feel angry and resist doing what they want." This item taps Millon's theory as to the motivation behind antisocial behavior (e.g., antisocials feel others want to dominate them so they dominate others and actively remain independent in order to resist such influences). Of course, the antisocial scale also contains items that are consistent with DSM-IV notions of antisocial behavior (e.g., "as a teenager I got into lots of trouble because of bad school behavior"). Thus Millon created an initial pool of face-valid items. Some were eliminated due to problems in readability, patient judgment, and sortings by clinicians. The remaining 1100 face-valid items were split into two equivalent forms.

After creating a pool of theoretically-derived items, the next step was to begin the process of internal-structural validation. He administered the two equivalent forms to clinical samples and retained only those items which had the highest item-total scale correlations. He then calculated item-scale intercorrelations as well as item endorsement frequencies and eliminated items with extreme endorsement frequencies using the operational definition of $<.15$ and $>.85$. The remaining 440 items were screened to assure an adequate number of items for each scale and to assure that overlapping scales and items were consistent with his theory. For example, there is a high correlation between the antisocial and narcissistic personality pattern scales. This was built in, so to speak, because Millon believes that, in nature, narcissism is part of the personality structure of the antisocial. This final set of items numbered 289.

For the external-criterion validation process, Millon then gave these items to 167 clinicians and asked them to complete a diagnostic form. The items were reduced to a total of 150. At this stage, scales on hypochondriasis, obession-compulsion, and sociopathy were eliminated and three scales were added (hypomania, alcohol abuse, and drug abuse) and the validation process described above was repeated until the final set of 175 items was established. The test was then published as the MCMI.

Because Millon revised his theoretical model somewhat and because DSM-III was also being revised, he also revised the MCMI by adding an aggressive (sadistic) scale and a self-defeating scale and also added three validly scales (Disclosure, Desirability, and Debasement). He also changed 45 items and constructed an item-weighting system, assigning higher weights to "prototype" items (i.e., those items essentially related to the disorder; e.g., "my

drug habits have gotten me into a good deal of trouble in the past" from Drug Abuse Scale T, MCMI-II).

Revision of the MCMI-II followed the three-step validation process detailed earlier. Two new scales were added, a depressive personality disorder scale and post-traumatic stress disorder scale. Noteworthy items (i.e., "critical items") now include items pertaining to child abuse and eating disorders, but these are not scored on any scale. The item-weighting system was changed from a three-point to a two-point scale. Prototype items are now given a weight of two rather than three. A total of 95 of the MCMI-II 175 items were changed. Scales that were about 25-items long in the MCMI-II are now about 15-items long in the MCMI-III. Many of these changes were introduced to bring the test into greater conformity with changes in DSM-IV.

In its final form, the MCMI-III consists of four Validity scales (the Validity Index and the three "Modifying indices" consisting of Disclosure (X), Desirability (Y), and Debasement (Z)), 11 Clinical Personality patterns (schizoid (1), avoidant (2A), depressive (2B), dependent (3), histrionic (4), narcissistic (5), antisocial (6A), aggressive/sadistic (6B), compulsive (7), passive-aggressive (8A), and self-defeating (8B), three scales measuring Severe Personality Pathology (schizotypal (S), borderline (C), and paranoid (P)), seven clinical syndromes (anxiety disorder (A), somatoform disorder (H), bipolar: manic disorder (N), dysthymic disorder (D), alcohol dependence (B), drug dependence (T), and post-traumatic stress (R)), and three severe clinical syndromes (thought disorder (SS), major depression (CC), and delusional disorder (PP)).

ADMINISTRATION AND SCORING

The MCMI-III was designed to be used with patients who are being evaluated or treated in a clinical/psychiatric setting when personality pathology is suspected as part of the clinical presentation. The test is not meant for nonclinical patients and use of this instrument with normals will distort the description of their personality and hence should not be done.

The MCMI-III is a 175-item self-report inventory, with items presented in a true-false dichotomy. The test can be administered to small groups or, more commonly, in an individual format. The respondents are asked to answer as honestly as possible and to express their true feelings and attitudes. The instructions are written in language requiring a sixth-grade reading ability.

Millon argues that, while abilities and traits are probably normally distributed and hence raw scores from ability and personality tests can be transformed to a normalized distribution, personality disorders are quite skewed in the general population. This means that normal distributions, such as z scores or T-scores, are inappropriate in such cases. Instead, MCMI-III raw scores are converted to Base Rate (BR) scores, which Millon describes as a transformed score which ensures that the proportion of patients scoring above each scale's cut-off point is equal to the actual prevalence among a representative population of patients who possess each scale's corresponding disorder. Millon arbitrarily selected a BR score of 60 as the mean BR score for all psychiatric patients who took the test in the standardization sample. A BR score of 30 was the mean score for testees without personality or clinical pathology. A BR score of 85 and above signifies the "most prominent" disorder (i.e., severe), a BR score of 75 to 84 reflects the "presence of characteristics" of the disorder (i.e., moderate), scores between 65 and 74 suggest the patient has some of the traits defined by the scale (i.e., mild), and scores between 0 and 64 are considered clinically nonsignificant. Different BR transformation tables are used for males and females for all scales except Scale X (disclosure).

Validity Indices: The MCMI-III has four scales that assess validity, e.g., test-taking attitude or the manner in which a person responded to the items. The first of these is the Validity Index, which consists of three items of an improbable nature. An answer of "true" to one of the items makes the accuracy of the test questionable. Two such answers result in profile invalidity and hence the test should not be interpreted. These items pertain to scenarios such as claiming to never have seen a car, being on the front cover of several magazines and flying across the ocean 30 times in one year. These items are likely to detect patients who are confused, dyslexic, or responding randomly to the items. The scores on the Validity Index do not appear on the profile sheet and are not converted to BR scores. The examiner is expected to consult answers to these items prior to scoring the test to ensure honest responses to these items.

My preference in orienting the person to take the MCMI-III is to tell the patient that "there are some 'trick' items on the test to see if you're paying attention—so pay attention." I have found this to be helpful in maximizing the probability of obtaining an interpretable profile.

The next validity scale, the Disclosure (X), was designed to detect patients who are self-revealing or highly defensive. It is not a scale with item composition. Rather it is an index that is based on the degree of positive or negative deviation from the midrange of an adjusted composite raw score total for the 11 Clinical Personality Patterns scales. A test protocol is considered invalid if the raw score on this scale is below 34 (e.g., excessive nondisclosure and denial of problems) or above 178 (e.g., gross exaggeration of problems and symptoms).

The Desirability Index (Y) is a 21-item scale that assesses the degree to which one patient is attempting to show oneself in a highly favorable light, as excessively virtuous, as emotionally stable, and as socially "together." BR scores above 74 on Scale Y suggest a possibly "faking good" response set. The mean score on this scale was 81, while the mean score of respondents instructed to "fake good" was BR96.

The *Debasement Index (Z)* is a 33-item scale which assesses the degree to which a respondent is "faking bad" or feigning symptoms or problems that are either exaggerated or do not exist at all. The mean BR score for patients was 87 whereas the mean BR score for respondents instructed to "fake bad" was BR108.

BR SCORE ADJUSTMENTS

After the raw scores have been converted to BR scores, these, in turn, may be adjusted based on one or more of the following considerations:

The *disclosure adjustment* adjusts scores on Scales 1 through PP. Scores on these scales are increased if scores on Scale X are <61 and decreased if scores on Scale X are >123. The exact amount of the adjustment depends on the value of Scale X. Note that it is impossible to invalidate scores on the personality disorder scales based on Scale X scores because adjustments are made to offset either a secretive or overly frank response set.

Scores are also adjusted by the *high anxiety/high depression adjustment*. If patients present in acute emotional turmoil characterized by acute anxiety or depression at the time of testing, these emotional states could distort the individual's true personality pattern. Millon determined which MCMI-III scales are most affected by such manifestations of psychological pain (i.e., avoidant [2B], depressive [2B], self-defeating [8B], schizotypal [S], and borderline [C]) and adjusts scores on those scales based on the final adjusted BR score on scales A (anxiety) and D (dysthymia), providing that BR scores on scales A and/or D are >74.

The *denial versus complaint adjustment* increases scores on scales 1 through 8B, provided the patient's BR scores are highest on the histrionic (4), narcissistic (5), or compulsive

(7) among scales 1 through 8B. In such cases, scores are increased on that scale by 8 BR points.

Scores are also adjusted if the patient is tested while an inpatient. This is done to counteract the tendency among hospitalized patients to not accurately report the severity of their psychological state. The *inpatient adjustment* increases scores on thought disorder (SS), major depression (CC), and delusional disorder (PP) provided that patient is an inpatient and the disorder has lasted four weeks or less.

Finally, no adjustments can decrease a score to below 1 or increase a score above 115.

This test is extremely difficult and quite cumbersome to score by hand. It is estimated that hand-scoring takes approximately 45 minutes, and there are serious doubts as to the accuracy and reliability of scores done by hand due to the possibility of multiple scorer error. Therefore, most psychologists prefer to have the test computer-scored by the test's publisher, National Computer Systems. However, this is somewhat costly, particularly for low volume operations. The difficulty of hand-scoring and the necessity of computer-scoring has been one of the complaints about this test.

INTERPRETIVE GUIDELINES

I recommend the following steps in interpreting the MCMI-III:

1. *Consider the context of testing.* Patients undergoing psychological evaluation for child custody are likely to respond to tests by denying symptoms or problems, whereas patients who are tested as part of an evaluation to determine sanity associated with a "not guilty by reason of insanity" plea to escape murder charges may respond to the test by exaggerating their symptoms and problems. Take into account the context of the evaluation and how this may affect a person's approach to testing.
2. *Examine the Validity Indices.*
   a. Make sure the patient has not omitted more than 10 items. If possible, have the patient go back and complete as many unanswered items as possible. Do not interpret the test if the number of unanswered items is >10.
   b. Make sure the Validity Index is <2 and preferably 0.
   c. Look at the Disclosure scale (X) and make sure BR>35 and <85. This is the only scale where both ends of the base rate distribution need to be interpreted. Low (but valid) scores reflect tendencies to deny psychological problems while scores >BR74 but <BR85 suggest unusual willingness to report problems.
   d. Look at the Desirability Scale (Y). If the BR scores are >74 suggest a response set to understate pathology, to deny problems and symptoms, and to place oneself in a positive light.
   e. If scores on the Debasement scale (Z) are >BR75, the patient may be exaggerating the extent of his or her problems.
3. *Examine the Clinical Personality Patterns and the Severe Personality Disorders.*
   a. Any scales with BR scores >84 mandate interpretation. Such scores indicate that the patient has the traits and characteristics associated with the disorder at diagnosable levels.
   b. Scores between BR>74 and BR<85 suggests the presence of traits associated with the content of the scale but at non-diagnosable levels.
   c. In general, if more than three scales reflect clinically significant elevations on the

clinical personality pattern scales and/or severe personality scales, interpret the more severe disorders.

d. Also, elevations on the severe personality disorder scales (S, C, P) normally are be given preference in interpretation over scales 1 through 8B, unless there is clinical justification not to do so.

e. Configural interpretation will result in more refined and more accurate interpretations. By configural interpretation I mean the combination of two or three clinical scales in a combined interpretation.

4. *Examine the Clinical Syndrome scales.*

a. Scores above BR84 indicate the presence of the syndrome at a diagnosable level, whereas scores between BR>74 and <85 suggest the presence of some but not all of the symptoms associated with the syndrome.

b. It is important not merely to diagnose a clinical syndrome but also to interpret it in the light of the context of the evaluation and to understand the meaning of the symptoms in the personality style/disorder in which it is embedded. For example, if a patient has clinically significant elevations on antisocial (6A), alcohol dependence (B), and anxiety disorder (A), then one possible interpretation is that the elevation on B may be residual effects of alcohol withdrawal and not truly an "anxiety reaction." However, if this same patient has significant elevations on 6A and A, the elevation on A would be unusual for someone with a purely antisocial personality and may suggest the individual is faced with some external problem (court case?) which is inducing a temporary level of stress that would not normally be a part of the personality structure.

5. *Review noteworthy responses.* Check any noteworthy responses that are highlighted in the endorsed direction.

6. Consider Extra-test information. Review patient background information, relevant history, and other available records and test results.

7. Establish a DSM-IV Diagnosis (using all relevant information).

8. Make treatment recommendations. Consider not only the likelihood of response to treatment for the clinical syndromes but, more importantly, how a patient is likely to behave and what barriers there might be to psychological treatment given the underlying personality structure.

CASE EXAMPLES

Case Example 1

Table 9.1 presents MCMI-III scores for a 44-year-old, divorced, unemployed, African-American male with 12 years of education. The patient's presenting problem was substance abuse, but he also reported a history of seizures for which he takes phenobarbital and low back pain for which he takes Motrin as needed.

He alleged daily alcohol use, heroin use twice a day through insufflation (snorting) at a cost of $100–$150 per day, and cocaine abuse (free-basing) by history. He had one prior inpatient treatment episode for alcohol abuse but relapsed about two months after discharge. He has never been in outpatient treatment. His stated motivation for requesting treatment was "I want to get over being depressed and my habit (heroin) is getting worse and I don't have much to live for". He wanted to be placed on methadone maintenance. He reported two prior

Table 9.1. MCMI-III Scores for Case Example 1

Scale	BR Score
Disclosure (X)	89
Desirability (Y)	39
Debasement (Z)	95
Schizoid (1)	69
Avoidant (2A)	79
Depressive (2B)	90
Dependent (3)	78
Histrionic (4)	28
Narcissistic (5)	32
Antisocial (6A)	77
Aggressive/Sadistic (6B)	49
Compulsive (7)	25
Passive-Aggressive (8A)	69
Self-Defeating (8B)	61
Schizotypal (S)	79
Borderline (C)	86
Paranoid (P)	74
Anxiety Disorder (A)	102
Somatoform Disorder (H)	87
Bipolar: Manic Disorder (N)	97
Dysthymic Disorder (D)	107
Alcohol Dependence (B)	97
Drug Dependence (T)	90
Post-Traumatic Stress (R)	97
Thought Disorder (SS)	77
Major Depression (CC)	107
Delusional Disorder (PP)	75

psychiatric treatments associated with attempted suicides via overdoses of barbiturates. He was hospitalized once at a VA psychiatric treatment unit and once at a State Mental Hospital. He alleges he is hearing voices telling him to steal and claims to see spots before his eyes that are not there.

He also reported a history of childhood physical abuse from his father, admitted to being a street fighter in a gang in his youth, and involved in homicidal behavior, but would not elaborate. He also admitted to repeated episodes of domestic abuse with his former wife and went to jail twice on battery convictions. He said he still routinely carries weapons on his person.

Notes from the clinical interview described this patient as lonely, introverted, and dysthymic, yet also aggressive and antisocial with borderline traits. He related in a somewhat deferential, respectful, and perhaps dependent manner. Mild auditory and visual hallucinations needed to be ruled out. His cognitions centered mostly on where he was going to live, how he would support himself, and how he would overcome his addiction. He dressed in neat but somewhat dirty clothing. He was not considered suicidal.

Interpretation

The patient's validity scales indicates that he was quite self-revealing (X) but what he had to say about himself was essentially negative (Z). Note that essentially all clinical syndrome scales are elevated in the clinically significant ranges but there is much more individu-

ation in scores among the personality disorder scales. I suspect this patient was rather honest in responding to questions pertaining to his personality style but tended to endorse an item as "true" whenever he came across an item pertaining to a symptom. Perhaps he responded in this way in the mistaken belief that this would increase his chances of being prescribed methadone, a narcotic drug.

This patient has essentially an introverted and detached personality style (2B2A) with a core of depressive personality traits (3) and antisocial traits complicating the clinical picture. Such patients have difficulty maintaining relationships and seem to prefer to be alone. They are generally bland and apathetic and tend to behave in a submissive and compliant manner. Yet he also has quixotic emotionality (C) that can erupt in antisocial ways (6A). Also, his detached and unemotional personality allows him to engage in antisocial behavior without the emotions of guilt, remorse, or empathy.

A few other comments are warranted. First, because of this patient's history of major depression with suicidal attempts, I am reluctant to describe him in terms of a depressive personality style, even though Scale 2B is his most elevated personality disorder scale. I attribute this elevation to his probable depressive disorder and suspect that scores on Scale 2B will abate as his clinical condition improves. Second, his introverted and antisocial style is consistent with his history and with the way he related to the interviewer during a mental status examination. Third, his past problems with domestic violence seem more attributable to his tendency to erupt with uncontrolled emotions when stressed (6A, C) than to a truly aggressive personality style (6B). Fourth, because of his exaggerated response set to clinical syndrome items, I am reluctant to include them in a report but would address his substance abuse and his clinical depression since those have been confirmed. We might speculate that anger is the major emotion driving this patient and that anger has been both turned in against himself (in depression and later suicide) and turned against others (in street fighting, murder, and domestic violence). Substance abuse may soothe him and quell this emotion for a time, but represents only a temporary solution. Millon would describe this personality style as a "restive depressive" and speculates that their behavior is designed to elicit sympathy, support, nurturance, and reassurance from significant others.

Computer-Generated Interpretive Report

While it is essential for an assessment psychologist to interpret an MCMI profile, many psychologists have relied on computer-assisted interpreted reports, which are now available on most major objective, self-report personality instruments. There are two computer narrative reports available for interpreting the MCMI-III. One is published by the test's publishers, National Computer Systems, and was written by Ted Millon. The other is published by Psychological Assessment Resources (PAR) and was written by this author. Below is an edited version of the PAR computer report generated for this patient's MCMI profile.

Sample Report

The following is a sample report:

The MCMI (as revised) was normed on individuals being evaluated or treated in mental health settings. Thus, the test should only be used with individuals who are in similar clinical settings for problems that are defined as psychological/psychiatric. Administering this test to people without clinical symptoms is inappropriate and will result in inaccurate descriptions of their functioning. Because this test is focused on personality disorders and clinical symptoms,

the report is necessarily focused on these problematic behaviors and cannot describe a person's strengths and competencies.

The interpretive information contained in this report should be viewed as only one source of hypotheses about the individual being evaluated. No decisions should be based solely on the information contained in this report. This material should be integrated with all other sources of information in reaching professional decisions about this individual.

This report is confidential and intended for use by qualified professionals only. It should not be released to the individual being evaluated.

Modifier Indices

Configuration: This patient may have a tendency toward self-abasement as a characterological trait or may have endorsed more problems and symptoms that would be determined by an objective review. The patient may have responded to the test items as a "cry for help," by endorsing so many problems to ensure that he would come to the clinician's attention. On the other hand, it is possible that the patient is seriously disturbed by many characterological problems. MCMI-III scoring adjustments have been made to correct for the "cry for help" tendency by decreasing scores on scales known to be affected by such a response strategy. However, the individual clinician must personally evaluate the extent to which such adjustments have made the necessary correction to improve profile validity. This patient also exhibits a high degree of self-disclosure. It is not unusual for high self-disclosing patients to also receive elevated scores on the Debasement Index.

Personality Style

This patient may be described as generally gloomy, pessimistic, overly serious, quiet, passive, and preoccupied with negative events. Such patients often feel inadequate and have low self-esteem. They tend to unnecessarily brood and worry and, though they are usually responsible and conscientious, they are also self-reproaching and self-critical, regardless of their level of accomplishment. They seem to be "down" all the time and are quite hard to please. They tend to find fault in even the most joyous experience. These people are often described negatively rather than positively. They feel it is futile to try to make improvements in themselves, in their relationships, or in any significant aspect of their lives because their incessant pessimism leads them toward a defeatist outlook. Their depressive demeanor often makes others around them feel guilty, since these patients are overly dependent on others for support and acceptance. They have difficulty expressing anger and aggression and perhaps displace it onto themselves. Interestingly, while their mood is often one of dejection and while their cognitions are often dominated by negative thoughts, they do not consider themselves depressed.

This personality style is present, even in the absence of a clinical depression. Their melancholic, sober demeanor, combined with their passivity and self-doubts, puts them at risk for occupational and marital problems. They are also at risk for dysthymia, if stressed with loss.

The patient may also be quite narcissistic, fearless, pugnacious, daring, blunt, aggressive, assertive, irresponsible, impulsive, ruthless, victimizing, intimidating, dominating, often energetic and competitive, but quite determined and independent. He is argumentative, self-reliant, revengeful and vindictive. He is chronically dissatisfied and harbors resentments against people who challenge, criticize, or express disapproval about his behavior.

He is characteristically touchy and jealous, broods over perceived slights and wrongs,

and provokes fear in those around him through his intimidating social demeanor. He tends to present with angry and hostile affect. He is suspicious and skeptical of the motives of other people, plans revenge for past grievances, and views others as untrustworthy. He avoids experiences of warmth, gentleness, closeness, and intimacy, viewing such involvements as a sign of weakness. These types of patients often ascribe their own malicious tendencies onto the motives of others. They feel comfortable only when they have power and control over others. They are continually on guard against anticipated ridicule and act out in a socially intimidating manner, desiring to provoke fear in others and to exploit them for self-gain. Such patients are driven by power, by malevolent projections, and by an expectation to anticipate suffering from others, so they react to maintain their autonomy and independence. Millon believes that their behavior is motivated by an expectancy that people will be rejecting and that other people are malicious, devious, and vengeful, thus justifying a forceful counteraction to maintain their own autonomy. They are alert for signs of ridicule and contempt, and they react with impulsive hostility in response to felt resentments. They are prone toward substance abuse, relationship difficulties, vocational deficits, and legal problems.

NOTE: It is possible to have an antisocial character style without engaging in antisocial (criminal) behavior.

While this patient may not meet all of the criteria to warrant a diagnosis of antisocial personality disorder, antisocial traits are present.

Clinical Syndromes

Dysthymic Disorder/Major Depression: The patient is reporting many problems and symptoms associated with dysthymia. These problems and symptoms include apathy, social withdrawal, guilt, pessimism, low self-esteem, feelings of inadequacy and worthlessness, self-doubts, and a diminished sense of pleasure. Generally such patients can't meet their day-to-day responsibilities but continue to experience chronic dysphoria. A diagnosis of depression is usually associated with scores at this level, with major depression or dysthymic disorder the most prevalent diagnoses. A more thorough clinical evaluation is recommended to determine if there are vegetative signs of depression, psychotic symptoms, and/or suicidal ideation.

Alcohol Dependence: This patient has reported symptoms and traits commonly associated with alcohol abuse and/or alcohol dependence. It is also possible that the patient has endorsed personality traits often seen in patients who subsequently develop problematic drinking. It is also possible that the patient has had problems with alcohol and is in recovery. A more thorough clinical evaluation should be conducted to determine the presence of any specific problems that may be associated with this condition (e.g., medical, social, legal, psychological, psychiatric, vocational, spiritual). Scores at this level almost always reflect a diagnosis associated with alcohol.

Drug Dependence: This patient has reported symptoms and traits commonly associated with alcohol and drug abuse and/or dependence. A more thorough clinical evaluation of the patient's drug and alcohol abuse history, pattern, and problems is recommended to determine the nature and extent of problems that may be associated with polysubstance abuse. Scores at this level almost always reflect a diagnosis associated with drug dependence. Additional scrutiny is necessary to determine if medical referral is necessary to deal with possible syndromes associated with drug and/or alcohol withdrawal.

Delusional Disorder: This patient is reporting many symptoms associated with paranoia. The patient's mood may be hostile, and the patient may be hypervigilant to perceived threat. Ideas of reference, thought control, or thought influence may be presence. Given this patient's apparent substance abuse, a drug-induced paranoia may also be present. A more thorough clinical evaluation is recommended to determine which specific symptoms are present, their cause, and what kind of clinical intervention is necessary. On the other hand, there is a high correlation between scales PP and B and T. Thus the patient's primary diagnosis may be substance abuse and traits and behaviors, such as hypervigilance, defensive scanning of the environment, a feeling that people are out to get him, etc., are really associated with the drug lifestyle rather than with clinical paranoia. A clinical evaluation is necessary to determine which diagnosis is the case.

Research: There is no published research on a codetype similar to the one obtained from this patient.

Computer-Derived Diagnoses

A computer-generated report follows.

I. Alcohol Abuse/Dependence
Drug Abuse/Dependence
r/o Drug-Induced Paranoia
r/o Dysthymia and/or Major depression
r/o Anxiety Disorder
II. Personality Disorder NOS, Antisocial and depressive traits.
End of report (Note: The original report was 11 pages, too lengthy for inclusion here).

Comment

This case illustrates some of the difficulties associated with computer-generated reports, particularly as they pertains to scale interactions. By scale interaction, we mean that elevations on one or more scales may attenuate or make more salient interpretations on another scale.

Note some inconsistencies in the personality description. One paragraph, describing the depressive aspect, reports that these patients are often responsible, whereas another paragraph, describing the antisocial aspect, reports that these patients are often irresponsible. The computer program cannot determine if a depression is superimposed over an antisocial personality or whether they exist independently of one another. Thus, the clinician must review and accurately interpret the test (e.g. not simply rely on computer interpretations), integrating this with other clinical information for final a decision. Remember, APA ethics stipulate that psychologists should be qualified to administer, score, and interpret the tests for which they are using computerized interpretations.

SUMMARY

The MCMI-III has become a mainstream clinical instrument to assess personality disorders and some clinical syndromes. Interpretation requires knowledge and understanding of base rate scores signs and symptoms of the major personality disorders, personality disorder

prototypes, and of psychodynamics, clinical syndromes, and how these fit into some type of theoretical foundation.

SUGGESTED READINGS

American Psychological Association Committee on Professional Standards (COPS) and Committee on Psychological Tests and Assessments (CPTA). *Guidelines for computer-based tests and interpretations.* Washington, DC: American Psychological Association.

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