Craig, R.J. (1999). Interpreting Personality Tests: A Clinical Manual for the MMPI-II, MCMI-III, CPI-R, 16PF. New York, NY: Wiley.

CHAPTER 2

Millon Clinical Multiaxial Inventory–III[1]

Background and History

In 1980 the American Psychiatric Association revised its diagnostic nomenclature and adopted a multiaxial system. AXIS II was assigned personality disorders. This was an important conceptual development, because the idea is that one cannot fully understand a clinical syndrome unless one takes into consideration the personality in which it is embedded. Since the introduction of AXIS II, there has been a spate of structured psychiatric interviews and psychological inventories to use in diagnosing personality disorders. Among these, the Millon Clinical Multiaxial Inventory (MCMI), as revised, has become the most popular and the most researched inventory for the assessment of personality disorders.

The MCMI, as revised, emanated from Millon's biopsychosocial and bioevolutionary theory of personality development. It was not meant to be congruent with various official diagnostic classification systems. However, over time, revisions of the MCMI have

[1] Some of the material in this section is an expanded version of material from *Psychological Assessment with the Millon Clinical Multiaxial Inventory (II): An Interpretive Guide* and from *MCMI II/III Interpretive System*, both by Robert J. Craig, Ph.D., copyright 1993 by Psychological Assessment Resources, Inc., and reproduced by special permission of the publisher, Psychological Assessment Resources, Inc., 16204 North Florida Avenue, Lutx, Florida 33549. Further reproduction is prohibited without permission of Psychological Assessment Resources, Inc.

become closely aligned with the *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition, or *DSM*-IV), although there are still disorders of personality (e.g., aggressive/sadistic and self-defeating) that are not a part of the *DSM*-IV Also, *DSM*-IV now includes, in the appendix, a passive-aggressive (negativistic) personality disorder that brings the definition of this disorder more in line with the way Millon has historically conceptualized it, so, at its heart, the MCMI-III is a test for personality disorders and a few major clinical syndromes.

Test Development

Millon used a three-step, state-of-the-art test development methodology to create and revise the MCMI. For step 1, the *substantive validity* phase, Millon created an item pool that was generated according to his theoretical model of personality development. These items were then submitted to a group of experts who were familiar with his theoretical model and asked them to rate each item in terms of its degree of correspondence and fit to this model. Items that were poorly related to the model were deleted from further consideration. Other items were reduced on rational grounds. The *structural validity* of the test was then established by assessing item endorsement patterns, internal consistency estimates, scale intercorrelations, temporal stability, and factor analysis. Finally, the test was submitted for *external validity* by assessing its convergent and discriminant validity. For convergent validity, the MCMI was correlated with measures of similar constructs using other tests. For discriminant validity, the MCMI was correlated with measures that should have no real relationship with MCMI scales. When all this information had been ascertained, only then was the test published and available to consumers.

Millon has revised the MCMI whenever *DSM* has been revised. The current version, MCMI-III, is relatively congruent with *DSM*-IV. This revised test now includes new scales for depressive personality disorder and for posttraumatic stress disorder. A few critical items are included in the test pertaining to eating disorders and childhood abuse but are not scored on any scale.

Base Rate Scores

Millon has persuasively argued that personality disorders are not normally distributed in the general population. In fact, the prevalence of these disorders rarely exceeds 3% to 5% and most occur at rates of only 1% to 2%. Therefore, it is inappropriate to convert raw scores of a distribution that is normally distributed, so Millon created the base rate (BR) score to reflect the skewed nature of the distribution in the population. A BR > 84 indicates that point in the distribution of scores at which the patient had all the characteristics that define the disorder at a diagnostic level. BR scores between 75 and 84 indicate the presence of traits associated with the disorder but below the diagnostic level. A BR of 60 is the mean BR score of everyone in the standardization sample, whereas a BR of 35 is the average score of people in nonclinical populations who participated in the test development phase. BR scores < 75, as a general rule, are not considered diagnostically significant and hence are not interpreted.

Interpreting the MCMI-III

MODIFIER (VALIDITY) INDEX

Validity Index

The Validity Index (VI) consists of three items of an improbable nature that, if endorsed as true, suggest invalidity. Although Millon suggests that the profile is invalid if two or more of these items are

endorsed as true, I recommend not interpreting the profile even if one of the items is marked true. The examiner needs to visually inspect the MCMI-III test answer sheet for items 65, 110, and 157 to see if any one is marked as true. The VI should be sensitive to random responding, confusion, or reading disorders.

Disclosure (Scale X)

Scale X assesses whether the patient is reporting a sufficient amount of information to produce a valid profile. It functions in a way analogous to the K Scale on the Minnesota Multiphasic Personality Inventory–2 (MMPI-2). Low scores suggest defensive reporting, whereas high scores suggest an unusually open and self-revealing attitude.

- Raw score < 34; This profile cannot validly be interpreted because the patient showed a strong tendency to deny personal problems, symptoms, and negative feelings and responded to the test with a defensive response set. The patient is denying the existence of psychological problems such that the MCMI-III may not be the most appropriate test to use for this particular assessment. It is suggested that the clinician review this matter with the patient to ascertain if the patient does not in fact have any psychological difficulty or whether the patient would be willing to report more accurately the extent of current problems on repeat test administration. Often, if the clinician explains the purpose of testing and how this test will be used in the best interest of helping the patient, then a repeat testing may produce a more valid picture of current psychological functioning.
- Raw score > 178: This profile cannot validly be interpreted because the patient showed a strong tendency to endorse so many personal problems, symptoms, and negative feelings that the information in the profile cannot be considered reliable.

Desirability (Scale Y)

Scale Y assesses whether the endorsed items on the MCMI-III are essentially of a more desirable (e.g., nonpathological) nature. Although low scores are generally not significant, a BR > 74 suggests the patient is presenting him- or herself as morally virtuous with few, if any, psychological problems. Scores on Scale Y do not invalidate a profile, because adjustments are made on scales known to be affected by high or low scores on Scale Y.

Debasement (Scale Z)

Scale Z determines whether the endorsed items are placing the patient in an unfavorable light (e.g., endorsing pathological items). It functions in an analogous manner to the F Scale on the MMPI-2. Low scores on Scale Z are generally not significant, whereas a BR between 75 and 84 suggests the patient is depreciating and devaluing him- or herself, has many emotional and behavioral problems, and is unusually self-disclosing. A BR > 84 suggests particular emotional distress that may be a cry for help—the patient is responding to the items in such a way as to call attention to his or her situation. Scores on Scale Z do not invalidate the profile, as adjustments are made on scales known to be affected by elevated scores on Scale Z.

Validity Scale Configurations

- Scores low for Scales X and Y with high Scale Z scores: suggests moderate exaggeration of current emotional problems
- Scores low for Scales X and Z and high for Scale Y (giving the appearance of an arrow pointing right): suggests emphasis on looking psychologically healthy
- Scores low for Scale Y and high for Scales X and Z (giving the appearance of an arrow pointing left): suggests emphasis on looking psychologically maladjusted
- Scale Z BR > 85 and Scale Y BR < 40: suggests symptom exaggeration

ONE-POINT CODES

One-point MCMI-III codes are those in which scores for only one Clinical Personality Pattern Scale or one Severe Personality Pathology Scale are BR > 74. When BR > 84, the patient has all of the defining features that characterize the disorder and would meet the criteria for that personality disorder. When BR is between 75 and 84, the patient has most but not all of the defining features and traits of the disorder but is below the diagnostic threshold.

Schizoid (Scale 1A: Passive-Detached)

Patients scoring high on Scale 1A appear apathetic, dull, quiet, colorless, vague, aloof, and introverted. They seem lost in their surroundings, blending into the background or engaging in vague pursuits. They show limited enthusiasm for most activities, preferring a solitary life and rarely initiating conversation. They seem indifferent to social relationships and do not seek out social contact. They seem to have a low need for social involvement, appear to require little affection, and lack both warmth and emotional expression. They manifest an emotionally bland appearance with flattened affect, combined with a lack of sensitivity to their own feelings and those of others. They lack an outward expression of aggression. They are often asexual, perhaps as a result of their relationship deficits. They are quite content to be passive, detached, and distant in their relationships. They have few friends, preferring the life of a loner. The detachment is not a defense mechanism. They are comfortable this way and prefer it, at least at the conscious level. Underneath this detachment lies a rich fantasy life and excessive daydreaming. Intrapsychically, they are in a chronic dilemma: They cannot be in a relationship without fearing engulfment, but they cannot be without a relationship without feeling intense aloneness. If this patient is married or in a committed relationship, problems are likely to arise, including spousal complaints of a lack of involvement and intimacy. Others see these people as strange and spacey. Relationship deficits are likely to be serious. These patients have low self-esteem, but more often, they have difficulty expressing how they feel about themselves. Their thinking can be obscure at times, with cognitive slippage occasionally manifested in speech. Their thoughts are vague and unfocused. Depersonalization, feelings of emptiness, and identity diffusion are also part of their personality structure. These patients tend to drift through marginal aspects of society. When social demands become inescapable, they are prone to anxiety reactions, somatoform disorders, and brief reactive psychoses.

Diagnosis, BR > 84: schizoid personality disorder

Diagnosis, BR 75 to 84: personality disorder not otherwise specified (NOS), schizoid personality traits

Suggested treatment goals:

- Develop ways to experience pleasure
- Increase social participation
- Increase social relatedness
- Reduce anxiety in social situations
- Become more active

Avoidant (Scale 2A: Active-Detached)

Patients with a BR > 84 present as socially awkward, withdrawn, introverted, and self-conscious. Because they are hypersensitive to rejection and both fear and expect negative evaluations, they either try to maintain a good social appearance despite their underlying fear or withdraw from social contacts. Tension, anxiety, and anger may also be present, but all stem from the same issue—a desire for social acceptance and a fear of rejection. Most often, these patients maintain a social distance to avoid any further experience of being rejected. They are devastated by perceived signs of disapproval and tend to withdraw, thus reducing the chance to enhance relationships. This circumstance results in social isolation despite a very strong need for social relatedness. These patients can put on a pleasant appearance to mask their underlying social anxiety, but they have a pervasive belief that others will be disparaging of them. Their essential conflict is a strong desire to relate but an equally strong expectation of disapproval, depreciation,

and rejection. This conflict results in keeping others at a distance and in loneliness, isolation, and continued shyness and timidity. They are at risk for social phobias.

Diagnosis, BR > 84: avoidant personality disorder

The behavior of patients with a BR between 75 and 84 is characterized by and motivated by a fear of rejection, thus leading to either a physical or emotional withdrawal in public to avoid social disapproval. Independent action may be stymied and emotions are suppressed because of insecurity. These patients feel inadequate, so they probably avoid actions that will lead to autonomy. Many such patients can hide their social anxiety and appear to be without problems. Closer scrutiny and a trusting relationship with the clinician may cause them to reduce their defensiveness and admit to their fears, since these fears are at the conscious level. Others act in a fearful, dependent, and avoidant manner such that their hesitancies and dependency are quite obvious to a casual observer.

This patient may not have all of the characteristics that define an avoidant personality disorder, but the presence of avoidant characteristics is strongly indicated in the profile.

Diagnosis: personality disorder not otherwise specified (NOS), avoidant personality traits

Suggested treatment goals:

- Reduce sensitivity to rejection
- Reduce anxiety in social situations
- Reduce expectations of ridicule and abuse
- Develop rewarding pleasurable activities
- Understand how behavioral withdrawal perpetuates fear of rejection

Depressive (Scale 2B: Passive-Detached)

Patients scoring high on Scale 2B are generally gloomy, pessimistic, overly serious, quiet, passive, and preoccupied with negative events. They 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 seem to find fault in even the most joyous experience. They 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 life because their incessant pessimism leads them toward a defeatist outlook. Their depressive demeanor often makes others around them feel guilty, because these patients are overly dependent on others for support and acceptance. They have difficulty expressing anger and aggression and perhaps introject it onto themselves. Interestingly, even though their mood is often one of dejection and their cognitions are often dominated by negative thoughts, they do not consider themselves to be depressed.

This personality style is present even in the absence of clinical depression. The melancholic, sober demeanor of these patients, 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 issues of loss.

Caution: Should the patient have clinical depression (see Scales D, page 186, and CC, page 188), the personality profile described here may be a manifestation of depression and not the patient's basic personality style. If this is true, then the symptoms and behaviors should abate when the depression has been successfully treated.

Diagnosis, BR between 75 and 84: personality disorder not otherwise specified (NOS), Depressive personality traits.

Suggested treatment goals:

- Reduce dysphoric mood, behavior, and cognitions
- Relate in a more cheerful manner
- Display humor
- Reduce passivity
- Expand activities designed to provide pleasure
- Reduce self-perpetuating activities that reinforce a sense of depression and dejection

- Understand the unconscious dynamics and seek a more realistic way to seek support
- Increase self-esteem

Dependent (Scale 3: Passive)

Patients with a BR > 84 tend to lean on other people for security, support, guidance, and direction. Such patients are passive, submissive, dependent, and self-conscious and lack initiative, confidence, and autonomy. Their temperament is pacifying and they try to avoid conflict. They acquiesce to maintain nurturance, affection, protection, and security. They can be expected to be obliging, docile, and placating, seeking relationships in which they can lean on others for emotional support. They have excessive needs both for attachment and to be taken care of, and they feel helpless when alone. They willingly submit to the wishes of others in order to maintain this security and this behavior tends to elicit helping and nurturing behaviors in those around them. When threatened with a loss of security, they seek out other relationships or institutions to take care of them. Their basic conflict is a fear of abandonment. This fear leads them to be overly compliant to ensure enduring protection for themselves. Their need for support is overwhelming. They prefer the dependent state and are genuinely docile. They have a self-image as a weak and fragile person, avoiding responsibilities and thereby precluding any chance of autonomy. When stressed (with a disruption of security), they are prone to develop anxiety and depressive disorders and substance abuse problems.

Note: Millon's theory argues that this style is not a veneer that masks deeply held resentments. Traditional psychodynamic theory posits that these people are quite angry and resentful toward those who provide them with the needed safety and security.

The core motivation for the dependent personality is to obtain and maintain nurturing and supportive relationships. It is quite possible that a person can act both passively and assertively to accomplish this central goal.

It has been theorized that some form of overprotection during childhood produces this style, in that these patients were not given the opportunity to learn autonomous behaviors.

Diagnosis, BR > 84: dependent personality disorder

The personality of patients with a BR between 75 and 84 shows markedly dependent features. This style reflects a conflict between dependence and independence that results in a fear of independence and a desire to withdraw from interpersonal relationships. This dependence–autonomy conflict is enhanced by a belief that reliance on others will bring disappointment and possible rejection, yet independent action will result in failure, shame, and ridicule. This conflict requires these patients to suppress any angry resentment they may feel to maintain relationships with those who can satisfy their basic needs. Patients who score at this level may be described as passive, docile, serene, quiet, compliant, obliging, and submissive.

When stress is minimal, these patients appear genuinely well adjusted, with few interpersonal difficulties, particularly if they are in a dominant/adaptive relationship in which the partner assumes primary responsibility and control for decision making. When stressed, particularly by threats to dependency security, these patients can be expected to engage in behaviors that will restore their basic dependency and to seek out people or institutions that will care for their needs. However, if unsuccessful, such patients are at risk for developing an anxiety disorder, a depressive disorder, or both. These patients may not meet all the criteria for a diagnosis of dependent personality disorder, but dependent traits are a salient aspect of the clinical presentation.

Diagnosis, BR between 75 and 84: personality disorder not otherwise specified (NOS), dependent traits

Suggested treatment goals:

- Become more assertive
- Reduce submissive behaviors
- Practice independent behaviors
- Increase self-reliance
- Reduce the need for support from others

- Increase self-perception of personal adequacy
- Reduce clinging behaviors

Histrionic (Scale 4: Active Dependent)

Patients who score at the level of a BR between 75 and 84 have very high needs for attention and praise, and they engage in self-dramatizing, gregarious, and socially engaging behaviors to maintain their security. Millon believes that the underlying fear of such patients is one of abandonment, so they demonstrate an admiration of significant others to assure themselves that they will not be left alone. Sometimes they will act in a subservient and overly compliant manner to maintain their security. Conflicts are avoided in favor of interpersonal harmony, even at the expense of their own values and beliefs. Marital problems may result from this particular personality style.

This patient may not meet the diagnostic criteria for a histrionic personality disorder, but histrionic traits are a part of the personality pattern.

Caution: See **Caution** paragraph in the section below.

Diagnosis, BR between 75 and 84: personality disorder not otherwise specified (NOS), histrionic traits

Expect patients with a BR > 84 to be overly dramatic, with strong needs to be the center of attention. Such patients are seductive—through speech, style, dress, or manner—and seek constant stimulation and excitement in an exhibitionistic atmosphere, requiring praise and attention. They are emotionally labile, are easily excited, and have frequent emotional outbursts. They are very gregarious, assertive, and socially outgoing, but they manipulate people to draw their approval and affection. They have strong needs for constant social acceptance. They are socially facile and seductively engaging, such that others are drawn to their enchanting manner. Relationships are often shallow and strained, however, as a result of their repeatedly dramatic and emotional outbursts and their self-centeredness. Denial and repression are their main defenses. They court the favor of others, but beneath this persona of confidence and self-assurance is a fear of autonomy and independence that mandates a constant need for acceptance and approval. They tend to displace anxieties when stressed. They are at risk for somatoform disorders and marital problems.

Millon has subdivided the histrionic personality disorder into six subtypes. These patients closely resemble the theatrical histrionic subtype. The cardinal features of this subtype are excessively dramatic, theatrical, and attention-getting behaviors designed to bring attention and approval. They are pure histrionics in the classic sense. They publicly profess undying adoration and approval toward their valued object, but this is easily seen as superficial and phony by those around them. Their unconscious use of denial, however, precludes them from this self-observation.

Caution: Empirical research has shown that Scale 4 (1) correlates positively with measures of mental health and negatively with measures of mental disorders; (2) infrequently appears in MCMI code types in psychiatric patients, except for substance abuse; and (3) is frequently the scale with the most elevated scores among nonclinical patients who have taken this test, particularly among women. These people would have a gregarious, extroverted, and socially engaging personality *style* but not a histrionic disorder. The clinician needs to evaluate which of these two possibilities is applicable to the particular patient.

Diagnosis, BR > 84: histrionic personality disorder

Suggested treatment goals:

- Reduce dramatic and theatrical behaviors
- Develop more authentic relationships through balanced interpersonal conduct
- Reduce manipulative and/or seductive behaviors
- Reduce excessive needs to seek attention and approval
- Reduce emotional overreacting

Narcissistic (Scale 5: Passive Independent)

Patients with high scores on Scale 5 are quite self-centered, expect people to recognize their special qualities, and require constant praise

and recognition. They have excessive expectations of entitlement and demand special favors. Grandiose statements of self-importance are readily elicited, and they consider themselves particularly attractive. They appear egocentric, arrogant, haughty, conceited, boastful, snobbish, pretentious, and supercilious. They will exploit people and manipulate them with an air of superiority. Although they can be momentarily charming, they have a deficient social conscience and think only of themselves. They show a social imperturbability and are likely to disregard social constraints. They exploit social relationships, are indifferent to the rights of others, relate in an autocratic manner, and expect others to focus on them. Even though this basic style often alienates other people, they respond with a sense of contempt and indifference because their inflated sense of self needs no confirmation from other people. Because of their grandiosity and arrogance, they rarely show signs of self-doubt. If they are humiliated or experience a narcissistic injury, they are prone to develop an affective disorder and perhaps a paranoid disorder. Many substance abusers also have a narcissistic personality style.

Millon has subdivided the narcissistic personality disorder into four subtypes. Patients with high scores on Scale 5 closely resemble the elitist narcissistic subtype. Patients of this subtype present a pure form of narcissism. The cardinal feature of this subtype is these patients' strong desire for public accolades and even celebrity status and for recognition of their special talents and accomplishments. However, an objective review of their life would suggest a large discrepancy between their actual deeds and the braggadocio about those deeds. They show the typical traits of the prototypical narcissist but feel excessively privileged. They are quite grandiose and self-aggrandizing.

Caution: Empirical research has shown that Scale 5 (1) correlates positively with measures of mental health and negatively with measures of mental disorders; (2) infrequently appears in MCMI code types in psychiatric patients, except for substance abuse; and (3) is frequently the scale with the most elevated scores among nonclinical patients who have taken this test, particularly among men. These people have a confidant demeanor with high self-regard, seem

socially charming, and perhaps even have a personality style of attention seeking but not a narcissistic personality disorder. The clinician needs to evaluate which of these two possibilities is applicable to the particular patient.

Diagnosis, BR > 84: narcissistic personality disorder

Diagnosis, BR between 75 and 85: personality disorder not otherwise specified (NOS), narcissistic traits

Suggested treatment goals:

- Reduce self-centeredness
- Take the other person's perspective into consideration
- Accept self on a more realistic basis
- Reduce grandiosity
- Learn how other people react and feel about narcissistic behavior; accept constructive feedback
- Prevent the development of a depressive disorder by reducing risk for narcissistic injury

Antisocial (Scale 6A: Active Independent)

Patients with high scores on Scale 6A are quite narcissistic, fearless, pugnacious, daring, blunt, aggressive and assertive, irresponsible, impulsive, ruthless, victimizing, intimidating, dominating, often energetic and competitive, but quite determined and independent. They are argumentative, self-reliant, revengeful, and vindictive. They are chronically dissatisfied and harbor resentment toward people who challenge, criticize, or express disapproval over their behavior. They are characteristically touchy and jealous, brood over perceived slights and wrongs, and provoke fear in those around them through their intimidating social demeanor. They tend to present with an angry and hostile affect. They are suspicious and skeptical of the motives of other people, plan revenge for past grievances, and view others as untrustworthy. They avoid expressions of warmth, gentleness, closeness, and intimacy, viewing such involvement as a sign of weakness. They often ascribe their own malicious tendencies to 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 others for self-gain. These patients are driven by power, by malevolent projections, and by an expectation of experiencing suffering at the hands of others, so they react to maintain their autonomy and independence. Millon believes 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 to substance abuse, relationship difficulties, vocational deficits, and legal problems.

Millon has subdivided the antisocial personality disorder into five types. Scale 6 patients closely resemble the covetous antisocial type. The cardinal feature of this subtype of patients is their incessant greediness. These patients feel constantly deprived and are motivated by envy and retribution to appropriate others' possessions. They tend to maintain a lifestyle of ostentatious displays of material possessions and concentrate their efforts at gaining power. They are completely self-centered and have little or no guilt or remorse for the anguish their deceit and exploitiveness have caused in others. These patients feel constantly deprived and use external signs of self-worth to satisfy an unconscious need for love and attention, which they feel they have not received in life. Thus, this style represents a pure form of the psychopathic personality.

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

Diagnosis, BR > 84: antisocial personality disorder

Diagnosis, BR between 75 and 84: personality disorder not otherwise specified (NOS), antisocial personality traits

Suggested treatment goals:

- Reduce antisocial behaviors
- Become more empathic
- Reduce manipulation and conning behaviors

- Reduce aggressive behaviors
- Channel negative emotions toward prosocial activities
- Reduce impulsivity
- Learn to appropriately express anger
- Do not violate the rights of others

Aggressive/Sadistic (Scale 6B: Active-Discordant)

Patients with high scores on Scale 6B may not be publicly antisocial, but their clinical features are quite similar to those of the antisocial personality style and may be considered as a more pathological variant of the antisocial style. They engage in behaviors that are abusive and humiliating and may violate the rights and feelings of others. They are aggressive, forceful, commanding, militant, domineering, hardheaded, hostile, dominating, intimidating, pervasively destructive, and brutal. They become combative when provoked, and they are antagonistic and disagreeable people. They tend to be touchy, excitable, and irritable and react angrily when confronted. In psychoanalytic terms, they are sadistic personalities. Some are able to sublimate these traits into socially approved vocations. When their autonomy is threatened, they are prone to spouse abuse and explosive outbursts that may result in legal problems.

Millon has subdivided the aggressive/sadistic personality disorder into four subtypes. Patients scoring high on Scale 6B closely resemble the explosive sadist subtype. Although these patients retain the essential features of the parent prototype, the cardinal feature of patients of the explosive sadistic subtype is their uncontrollable rage, usually expressed at those weaker than themselves. These patients erupt in violent behavior with unpredictable belligerent acts that are often irrational and of ferocious intensity. Although the effects of such behavior are to intimidate and control people, the actual motivation for the explosiveness is to release anger and tension associated with a feeling of humiliation and betrayal.

Diagnosis, BR > 74: personality disorder not otherwise specified (NOS), aggressive personality traits

Suggested treatment goals:

- Reduce/eliminate physical and/or verbally aggressive behavior
- Control temper
- Reduce hostile and volatile moods
- Interpret the environment as less menacing
- Acquire prosocial behaviors
- Reduce emphasis on controlling others
- Do not harm anyone
- Manage anger more appropriately

Compulsive (Scale 7: Passive-Ambivalent)

Patients with high scores on Scale 7 are behaviorally rigid, constricted, conscientious, polite, organized, meticulous, punctual, respectful, often perfectionistic, formal, prudent, overconforming, cooperative, compliant with rules, serious, moralistic, self-righteous and self-disciplined, efficient, and relatively inflexible. They place high demands on themselves. They are emotionally restrained, suppressing strong resentments and anger, and they appear tense and grim but emotionally controlled. They are socially conforming and prone to a repetitive lifestyle, as a result of engaging in a series of patterned behaviors and rules that must be followed. They have fears of social disapproval and are a model of propriety and restraint. They show excessive respect for authority yet may treat subordinates in an autocratic manner. They operate from a sense of duty that compels them not to let others down, thus risking the condemnation of authority figures. They show an anxious conformity. They strive to avoid criticism but expect it because of what they perceive to be their personal shortcomings. They fear making mistakes because of expected disapproval. Their behavior stems from a conflict between a felt hostility that they wish to express and a fear of social disapproval should they expose this underlying oppositional resentment. This circumstance forces them to become overconforming, thus placing high demands on themselves that serve to control this intense anger, which occasionally breaks through into their behavior. Obsessive thinking may or may nor be present.

Millon has subdivided the compulsive personality disorder into five subtypes. Patients with high Scale 7 scores closely resemble the conscientious Compulsive. Although their behavior is an example of a relatively pure form of the prototypal compulsive personality style, the cardinal feature of patients of this subtype is their excessive compliance, obedience, conformity, and desire to please authority figures. They impress people with their conscientiousness, but underneath their obedience is a fear of making mistakes and receiving disapproval. Their (largely unconscious) feelings of inadequacy and fear of failure compel them to maintain a rigid approach to life's tasks.

Caution: Empirical research has shown that Scale 7 (1) correlates positively with measures of mental health and negatively with measures of mental disorders; (2) infrequently appears in MCMI codetypes in psychiatric patients; (3) is frequently the scale with the most elevated scores among nonclinical patients who have taken this test, particularly among men; and (4) is the only study that has used the MCMI with patients with an obsessive-compulsive disorder who did not have elevations on Scale 7. Thus, patients with elevated scores on Scale 7 would be conscientious, rule bound, and orderly, suggesting a compulsive personality style but not a compulsive disorder. The clinician needs to evaluate which of these two possibilities is applicable to the particular patient.

Diagnosis, BR > 84: compulsive personality disorder

Diagnosis, BR between 75 and 84: personality disorder not otherwise specified (NOS), compulsive traits

Suggested treatment goals:

- Reduce rigidity
- Reduce compulsive behaviors
- Practice spontaneity and flexibility
- Reduce fears of disapproval
- Understand early childhood experiences that resulted in a compulsive personality style
- Reduce tendencies toward perfectionism if they interfere with life satisfaction
- Learn to take risks

Passive-Aggressive (Negativistic: Scale 8A: Active Ambivalent)

Patients with high scores on Scale 8A display a mixture of passive compliance and obedience at one time and oppositional and negativistic behavior the next time. They are moody, irritable, and hostile; manifest a grumbling, pessimistic demeanor; and are erratically and explosively angry and stubborn at one moment and feel guilty and contrite at the next moment. Disillusionment seems to permeate their lives. They feel misunderstood, so they vacillate between passive dependency and stubborn contrariness, which provokes discomfort and exasperation in those around them. They expect disappointment and maintain an unstable and conflictual role in relations with others. They sulk, feel unappreciated and/or feel they are being treated unfairly, constantly complain, and are persistently petulant and discontented. They often have problems with authority and, if employed, have job difficulties.

Commentary: Elevations on Scale 8A are a good indicator of problems with authority and with criminal behaviors or potential criminal behavior. Also, clinical elevations on this scale appear in a number of profile codes involving psychiatric patients. Patients with elevations on Scale 8A warrant close clinical evaluation.

Diagnosis, BR > 74: Personality not otherwise specified (NOS), passive-aggressive (negativistic) traits

Suggested treatment goals:

- Reduce negative behaviors
- Reduce argumentativeness
- Reduce moodiness
- Learn to appropriately express anger
- Learn to have a more thoughtful manner
- Learn to recognize and change manipulative behavior patterns
- Control emotions

Self-Defeating (Scale 8B: Passive-Discordant)

Patients with high scores on Scale 8B relate in a self-sacrificing, martyr-like manner, allowing others to take advantage of them. They seem to search for relationships in which they can lean on others for security and affection. Typically, they act in an unassuming manner, denigrating themselves into believing they deserve their fate. Thus, this pattern is repeated in most relationships, making them prone to being abused. It is conceptually similar to the analytic concept of masochism.

Diagnosis, BR > 74: personality disorder not otherwise specified (NOS), self-defeating (masochistic) traits

Suggested treatment goals:

- Become more assertive
- Reduce tendencies to be taken advantage of
- Develop a positive self-concept
- Reduce behaviors that provoke others
- Reduce dependency
- Reduce victimization, if applicable
- Reduce deferential interpersonal conduct
- Acknowledge and deal with feelings of resentment

Schizotypal (Scale S: Active-Dependent)

The profile pattern of patients with high scores on Scale S represents a more severe dysfunctional variant of the schizoid or the avoidant personality disorder. Millon subdivides this disorder into two types. The active variant is characteristically anxious, wary, and apprehensive, whereas the passive type is characteristically emotionally bland with a flat affect.

These patients have behavioral peculiarities and eccentricities and seem detached from the world around them, appearing strange and different. They tend to lead meaningless lives, drifting aimlessly from one activity to the next, remaining on the periphery of society. They are socially detached and isolated and show a pervasive discomfort with others. They have few, if any, personal attachments and rarely develop any intimate relationships. Their thinking is irrelevant, tangential, disorganized, or autistic and they are suspicious of others. Cognitive confusion and perceptual distortions are the rule. They are self-absorbed and ruminative with feelings of derealization.

They are prone to decompensate into schizophrenia if sufficiently stressed. If BR > 84, then because of the severity of the disorder, a clinical evaluation is needed to determine if the patient can function on a daily basis.

Diagnosis, BR > 84: schizotypal personality disorder

Diagnosis, BR between 75 and 84: personality disorder not otherwise specified (NOS) schizotypal traits

Suggested treatment goals for patient:

- Reduce intensity of thought disorder
- Improve relationship skills
- Increase social skills and social participation
- Become active in at least one desired activity

Suggested treatment goals for therapist:

- Monitor for possible deterioration and decompensation
- Evaluate the need for psychotropic medication
- Provide a supportive therapeutic environment

Borderline (Scale C)

Patients with high scores on Scale C have conflicting and ambivalent feelings, intensely resenting those on whom they depend yet being preoccupied with maintaining their emotional support. They show persistent attachment disorders with patterns of intense but unstable relationships. They tend to experience intense but labile emotions and frequent mood swings with recurring periods of depression, anxiety, or anger followed by dejection and apathy. They often will present with intense affect and with a history of impulsive behaviors. Manifestations of cheerfulness are often temporary coverups that mask deep fears of insecurity and fears of abandonment. They have strong dependency needs and are preoccupied with seeking attention and emotional support and need considerable reassurance. These people are particularly vulnerable to separation from those who emotionally support them. Feelings of idealization are usually followed by feelings of devaluation, and there is considerable interpersonal ambivalence. They lack a clear sense of their own identity, and this uncertainty leads them to constantly seek approval, attention, and reaffirmation. Splitting and projective identification are their major defenses. They often have a punishing conscience and are prone to acts of self-mutilation and suicidal gestures. They are also prone toward brief, psychotic episodes and substance abuse.

Diagnosis, BR > 84: borderline personality disorder

Diagnosis, BR between 75 and 84: personality disorder not otherwise specified (NOS), borderline traits

Suggested treatment goals:

- Reduce fears of abandonment
- Reduce dependent behaviors
- Reduce anxiety
- Learn to express anger more appropriately
- Relate to others on a more realistic basis
- Reduce impassivity
- Agree to work within the limits defined by the therapist

Paranoid (Scale P)

Millon believes that patients who have high scores on Scale P are conflicted between issues of control and affiliation. They vigilantly mistrust others and have an abrasive, hostile, irritable, touchy, and irascible demeanor that readily attacks and humiliates anyone whom they perceive as trying to control them. They may become belligerent, with such behavior stemming from distorted cognitions or actual delusions. They tend to magnify interpersonal slights, are prone to distort events to support their own suspicions, and strongly resist external influence. They are fiercely independent and tend to be provocative in interpersonal relationships, precipitating fear and exasperation in those around them. Their thinking is rigid and they often become argumentative. Projection is their main defense. They are particularly sensitive to perceived threats to their own sense of self-determination. Delu-

sions of grandeur or persecution or ideas of reference may be present in the more extreme form of the disorder.

Diagnosis, BR > 84: paranoid personality disorder

Diagnosis, BR between 75 and 84: personality disorder not otherwise specified (NOS), paranoid personality traits

Suggested treatment goals:

- Learn to trust at least one person
- Reduce delusional thinking
- Reduce anger, hostility, and suspiciousness
- Reduce isolation
- Learn to express anger in a more socially approved way
- Develop a more realistic appraisal of personal environment

ONE-POINT CODE TYPES WITH ONE SUBSPIKE

One–point code types with one subspike are highlighted by scores for one clinical personality pattern scale of BR > 84 and for one clinical personality pattern scale of BR between 75 and 84. It is suggested that the reader review the interpretation for each of these scales as detailed under One-Point Codes (pages 106–124). Here, for illustration, only the interpretation for code type 1'2A (schizoid, avoidant) is presented.

1'2A

Patients with a 1'2A code appear apathetic, dull, quiet, colorless, vague, aloof, and introverted. They seem lost in their surroundings, blending into the background or engaging in vague pursuits. They show limited enthusiasm for most activities, preferring a solitary life and rarely initiating conversation. They seem indifferent to social relationships and do not seek out social contact. They seem to have a low need for social involvement, appear to require little affection, and lack both warmth and emotional expression. They manifest an emotionally bland appearance with flattened affect, combined with a lack of sensitivity to their own feelings and those of others. They lack an outward expression

of aggression. They are often asexual, perhaps as a result of their relationship deficits. They are quite content to be passive, detached, and distant in their relationships. They have few friends, preferring the life of a loner. The detachment is not a defense mechanism. They are comfortable this way and prefer it, at least at the conscious level. Underneath this detachment lies a rich fantasy life and excessive daydreaming. Intrapsychically, they are in a chronic dilemma because they cannot be in a relationship without fearing engulfment yet cannot be without a relationship without feeling intense aloneness. If this patient is married or in a committed relationship, problems are likely to arise, including spousal complaints of a lack of involvement and intimacy. Others see these people as strange and spacey. Relationship deficits are likely to be serious. These patients have low self-esteem, but more often, they have difficulty expressing how they feel about themselves. Their thinking can be obscure at times, with cognitive slippage occasionally manifested in speech. Their thoughts are vague and unfocused. Depersonalization, feelings of emptiness, and identity diffusion are also part of their personality structure. These patients tend to drift through marginal aspects of society. When social demands become inescapable, they are prone to anxiety reactions, somatoform disorders, and brief reactive psychoses.

These patients' behavior is characterized by and motivated by a fear of rejection, thus leading to either a physical or emotional withdrawal in public to avoid social disapproval. Independent action may be stymied and emotions are suppressed because of insecurity. These patients feel inadequate and so probably avoid actions that will lead to autonomy. Many such patients are able to hide their social anxiety and appear to be without problems. Closer scrutiny and a trusting relationship with the clinician may cause them to reduce their defensiveness and admit to their fears, because these fears are at the conscious level. Others act in a fearful, dependent, and avoidant manner such that their hesitancies and dependency are quite obvious to a casual observer. These patients may not have all the characteristics that define an avoidant personality disorder, but the presence of avoidant characteristics is strongly indicated in the profile.

Diagnosis: schizoid personality disorder with avoidant personality traits

TWO-POINT CODES

Two-point codes are codes for which scores for two clinical personality pattern scales are BR > 84 and for which scores for the remaining clinical personality patterns are BR < 74. Because Millon subdivided prototype personality disorders into several subtypes with many represented by two-point codes, what are listed here are interpretations primarily for those subtypes that represent the more common MCMI two-point codes as well. If a patient has a one-point code with one subspike, it is recommended that the code types contained in this section also be considered.

12A′, or 1S

Patients with a 12A′ (or 1S) code appear apathetic, dull, quiet, colorless, vague, aloof, and introverted. They seem lost in their surroundings, blending into the background or engaging in vague pursuits. They show limited enthusiasm for most activities, preferring a solitary life and rarely initiating conversation. They seem indifferent to social relationships and do not seek out social contact. They appear both to have a low need for social involvement and to require little affection, and they lack both warmth and emotional expression. They manifest an emotionally bland appearance with flattened affect, combined with a lack of sensitivity to their own feelings and those of others. They lack an outward expression of aggression. They are often asexual, perhaps as a result of their relationship deficits. They are quite content to be passive, detached, and distant in their relationships. They have few friends, preferring the life of a loner. The detachment is not a defense mechanism. They are comfortable this way and prefer it, at least at the conscious level. Underneath this detachment lies a rich fantasy life and excessive daydreaming. Intrapsychically, they are in a chronic dilemma: They cannot be in a relationship without fearing engulfment, yet they cannot be without a relationship without feeling intense aloneness. If this patient is married or in a committed relationship, problems are likely to arise, such as spousal complaints of a lack of involvement and intimacy. Others see these people as strange and

spacey. Relationship deficits are likely to be serious. These patients have low self-esteem, but more often, they have difficulty expressing how they feel about themselves. Their thinking can be obscure at times, with cognitive slippage occasionally manifested in speech. Their thoughts are vague and unfocused. Depersonalization, feelings of emptiness, and identity diffusion are also part of their personality structure. These patients tend to drift through marginal aspects of society. When social demands become inescapable, they are prone to anxiety reactions, somatoform disorders, and brief reactive psychoses.

These patients' behavior is also characterized by and motivated by a fear of rejection. This leads to either a physical or an emotional withdrawal in public to avoid social disapproval. Independent action may be stymied and emotions are suppressed because of insecurity. These patients feel inadequate, so they probably avoid actions that will lead to autonomy.

Millon has subtyped the schizoid personality disorder into four variants, reflecting more central personality difficulties within his domain model. Patients with a 12A′ code closely resemble the remote schizoid type. They are characterized by emotional distance, inaccessibility, and isolation. They seem to have few social interests and drift in and out of peripheral social roles, with little apparent interest in sexuality. They often rely on public institutions for self-care. They appear intellectually dull and have serious relationship difficulties.

Diagnosis: schizoid personality disorder

12B′

Patients with a 12B′ code appear apathetic, dull, quiet, colorless, vague, aloof, and introverted. They seem lost in their surroundings, blending into the background or engaging in vague pursuits. They show limited enthusiasm for most activities, preferring a solitary life and rarely initiating conversation. They seem indifferent to social relationships and do not seek out social contact. They appear both to have a low need for social involvement and to require little affection, and they lack both warmth and emotional expression. They manifest an emotionally bland appearance with flattened affect, combined with a lack of sensitivity to

their own feelings and those of others. They do not outwardly express aggression. They are often asexual, perhaps as a result of their relationship deficits. They are quite content to be passive, detached, and distant in their relationships. They have few friends, preferring the life of a loner. The detachment is not a defense mechanism. They are comfortable this way and prefer it, at least at the conscious level. Underneath this detachment lies a rich fantasy life and excessive daydreaming. Intrapsychically, they are in a chronic dilemma: They cannot be in a relationship without fearing engulfment, yet they cannot be without a relationship without feeling intense aloneness. If these patients are married or in a committed relationship, problems are likely to arise, such as spousal complaints of a lack of involvement and intimacy. Others see these people as strange and spacey. Relationship deficits are likely to be serious. These patients have low self-esteem, but more often, they have difficulty expressing how they feel about themselves. Their thinking can be obscure at times, with cognitive slippage occasionally manifested in speech. Their thoughts are vague and unfocused. Depersonalization, feelings of emptiness, and identity diffusion are also part of their personality structure. These patients tend to drift through marginal aspects of society. When social demands become inescapable, they are prone to anxiety reactions, somatoform disorders, and brief reactive psychoses.

Millon has subtypes the schizoid personality disorder into four variants, reflecting more central personality difficulties within his domain model. Patients with a 12B′ closely resemble the languid schizoid type. The cardinal feature of this schizoid subtype is slow motoric expression. These patients are characterized by a phlegmatic temperament, deficient energy level, a slow personal tempo, delayed reactivity to stimulus enrichment, and a weary exterior. They relate to others in a quiet, dependent style and rarely show affection.

Diagnosis: schizoid personality disorder

17′

Patients with a 17′ code appear apathetic, dull, quiet, colorless, vague, aloof, and introverted. They seem lost in their surroundings,

blending into the background or engaging in vague pursuits. They show limited enthusiasm for most activities, preferring a solitary life and rarely initiating conversation. They appear indifferent to social relationships and do not seek out social contact. They give the impression both of having a low need for social involvement and of requiring little affection and lack both warmth and emotional expression. They manifest an emotionally bland appearance with flattened affect, combined with a lack of sensitivity to their own feelings and those of others. They do not outwardly express aggression. They are often asexual, perhaps as a result of their relationship deficits. They are quite content to be passive, detached, and distant in their relationships. They have few friends, preferring the life of a loner. The detachment is not a defense mechanism. They are comfortable this way and prefer it, at least at the conscious level. Underneath this detachment lies a rich fantasy life and excessive daydreaming. Intrapsychically, they are in a chronic dilemma: They cannot be in a relationship without fearing engulfment, yet they cannot be without a relationship without feeling intense aloneness. If these patients are married or in a committed relationship, problems are likely to arise, such as spousal complaints of a lack of involvement and intimacy. Others see these people as strange and spacey. Relationship deficits are likely to be serious. These patients have low self-esteem, but more often, they have difficulty expressing how they feel about themselves. Their thinking can be obscure at times, with cognitive slippage occasionally manifested in speech. Their thoughts are vague and unfocused. Depersonalization, feelings of emptiness, and identity diffusion are also part of their personality structure. These patients tend to drift through marginal aspects of society. When social demands become inescapable, they are prone to anxiety reactions, somatoform disorders, and brief reactive psychoses. These patients are also behaviorally rigid, constricted, serious, and emotionally restrained, suppressing their strong resentments and anger, and they appear tense and grim.

Millon has subtyped the schizoid personality disorder into four variants, reflecting more central personality difficulties within his domain model. Patients with a 17′ code closely resemble the affect-

less schizoid type. The cardinal feature of this schizoid subtype is marked deficit in relational capacity, particularly as it pertains to the normal exchange of emotions and feelings. They seem cold, emotionally flat, and unperturbed by events that would normally stimulate the emotions.

Diagnosis: schizoid personality disorder

1S′

Patients with a 1S′ code appear apathetic, dull, quiet, colorless, vague, aloof, and introverted. They seem lost in their surroundings, blending into the background or engaging in vague pursuits. They show limited enthusiasm for most activities, preferring a solitary life and rarely initiating conversation. They seem indifferent to social relationships and do not seek out social contact. They appear both to have a low need for social involvement and to require little affection, and they lack both warmth and emotional expression. They manifest an emotionally bland appearance with flattened affect, combined with a lack of sensitivity to their own feelings and those of others. They do not outwardly express aggression. They are often asexual, perhaps as a result of their relationship deficits. They are quite content to be passive, detached, and distant in their relationships. They have few friends, preferring the life of a loner. The detachment is not a defense mechanism. They are comfortable this way and prefer it, at least at the conscious level. Underneath this detachment lies a rich fantasy life and excessive daydreaming. Intrapsychically, they are in a chronic dilemma: They cannot be in a relationship without fearing engulfment, yet they cannot be without a relationship without feeling intense aloneness. If these patients are married or in a committed relationship, problems are likely to arise, such as spousal complaints of a lack of involvement and intimacy. Others see these people as strange and spacey. Relationship deficits are likely to be serious. These patients have low self-esteem, but more often, they have difficulty expressing how they feel about themselves. Their thinking can be obscure at times, with cognitive slippage occasionally manifested in speech. Their thoughts are vague and unfocused. Depersonalization, feelings of emptiness, and identity

diffusion are also part of their personality structure. These patients tend to drift through marginal aspects of society. When social demands become inescapable, they are prone to anxiety reactions, somatoform disorders, and brief reactive psychoses.

Millon has subtyped the schizoid personality disorder into four variants, reflecting more central personality difficulties within his domain model. Patients with a 1S′ code closely resemble the Depersonalized schizoid type. The cardinal features of patients of this schizoid subtype are their disengagement both from their sense of self and from others, their sense of depersonalization, their disengagement, and their dissociated appearance. They occasionally seem oblivious to their surroundings, stare into space, appear to be in a dreamlike trance, or are simply inattentive and preoccupied. They have severe relationship deficits and seem lost within themselves.

Diagnosis: schizoid personality disorder

2A2B′

Patients with a 2A2B′ code present as socially awkward, withdrawn, introverted, and self-conscious. Because they are hypersensitive to rejection and both fear and expect negative evaluations, they either try to maintain a good social appearance despite their underlying fear or they withdraw from social contacts. Tension, anxiety, and anger may also be present, but all stem from the same issue—a desire for social acceptance and a fear of rejection. Most often, they maintain a social distance to avoid any further rejection. They are devastated by perceived signs of disapproval and tend to withdraw, thus reducing their chances of enhancing relationships. This circumstance results in social isolation despite a very strong need for social relatedness. These patients can put on a pleasant appearance to mask their underlying social anxiety, but they have a pervasive belief that others will be disparaging of them. Their essential conflict is a strong desire to relate but an equally strong expectation of disapproval, depreciation, and rejection. This conflict results in their keeping others at a distance but also results in loneliness, isolation, and continued shyness and timidity. They are at risk for social phobias.

Millon has subtyped the avoidant personality disorder into four variants, reflecting more central personality difficulties with his domain model. Patients with a 2A2B′ code closely resemble the self-deserting avoidant type. The cardinal features of these patients are social aversion and self-devaluation. To avoid public exposure and humiliation (because of anticipated rejection), these patients withdraw from social relationships. Their increasing loneliness results in increased melancholy, and their feelings of disconnection combined with self-devalution put them at risk for suicide.

Diagnosis: avoidant personality disorder

2A3

Patients with a 2A3 code present as socially awkward, withdrawn, introverted, and self-conscious. Because they are hypersensitive to rejection and both fear and expect negative evaluations, they either try to maintain a good social appearance despite their underlying fear or they withdraw from social contacts. Tension, anxiety, and anger may also be present, but all stem from the same issue—a desire for social acceptance and a fear of rejection. Most often, they maintain a social distance to avoid any further experience of being rejected. They are devastated by perceived signs of disapproval and tend to withdraw, thus reducing their chances of enhancing relationships. This circumstance results in social isolation despite a very strong need for social relatedness. These patients can put on a pleasant appearance to mask their underlying social anxiety, but they have a pervasive belief that others will be disparaging of them. Their essential conflict is a strong desire to relate but an equally strong expectation of disapproval, depreciation, and rejection. This conflict results in their keeping others at a distance but also results in loneliness, isolation, and continued shyness and timidity. They are at risk for social phobias.

Millon has subtyped the avoidant personality disorder into four variants, reflecting more central personality difficulties within his domain model. Patients with a 2A3 code closely resemble the phobic avoidant type. Patients of this subtype retain the essential core features of the avoidant type and have phobic anxieties such that they are chronically tense and anxious. Millon has described them as a mixture of avoidant and dependent personalities who are unable to control their anxieties over anticipated rejection. These patients often channel their fears onto an external object and also restrict their social relatedness to one or two people who will cater to their dependency needs. Although these patients may tolerate such support, they do so with considerable distrust and discomfort. Because of these cardinal features, it is suggested that the clinician explore for social phobias.

Diagnosis: avoidant personality disorder

2A8A′

Patients with a 2A8A′ code present as socially awkward, withdrawn, introverted, and self-conscious. Because they are hypersensitive to rejection and both fear and expect negative evaluations, they either try to maintain a good social appearance despite their underlying fear or they withdraw from social contacts. Tension, anxiety, and anger may also be present, but all stem from the same issue—a desire for social acceptance and a fear of rejection. Most often, they maintain a social distance to avoid any further experience of being rejected. They are devastated by perceived signs of disapproval and tend to withdraw, thus reducing their chances of enhancing relationships. This circumstance results in social isolation despite a very strong need for social relatedness. These patients can put on a pleasant appearance to mask their underlying social anxiety, but they have a pervasive belief that others will be disparaging of them. Their essential conflict is a strong desire to relate but an equally strong expectation of disapproval, depreciation, and rejection. This conflict results in keeping others at a distance but also results in loneliness, isolation, and continued shyness and timidity. They are at risk for social phobias.

Diagnosis: avoidant personality disorder

The behavior of patients with a BR between 75 and 84 is characterized by and motivated by a fear of rejection, thus leading to either a

physical or emotional withdrawal in public to avoid social disapproval. Independent action may be stymied and emotions are suppressed because of insecurity. These patients feel inadequate, so they probably avoid actions that will lead to autonomy. Many such patients can hide their social anxiety and appear to be without problems. Closer scrutiny and a trusting relationship with the clinician may cause them to reduce their defensiveness and admit to their fears, because these fears are at the conscious level. Others act in a fearful, dependent, and avoidant manner such that their hesitancies and dependency are quite obvious to a casual observer.

Millon has subtyped the avoidant personality disorder into four variants, reflecting more central personality difficulties within his domain model. Patients with a BR between 75 and 84 closely resemble the conflicted avoidant type. Patients of this subtype retain the essential core features of the avoidant type and have the features of the passive-aggressive (negativistic) personality. The cardinal feature of the conflicted avoidant patient is fear of both dependence and independence. Thus, the behavior of these patients is characterized by internal struggles to withdraw from social contacts and a desire to become involved in closer relationships. This conflict results in feelings of low self-esteem and a discontented, petulant exterior that may show paroxysmal hostility at the slightest provocation. This is followed by remorse, regret, then further acting out in an endless cycle of outbursts and moodiness. Their deep social mistrust and anticipated rejection and depreciation make it extremely difficult to retain stable interpersonal relationships.

Diagnosis: avoidant personality disorder

2AP

Patients with a 2AP code present as socially awkward, withdrawn, introverted, and self-conscious. Because they are hypersensitive to rejection and both fear and expect negative evaluations, they either try to maintain a good social appearance despite their underlying fear or withdraw from social contacts. Tension, anxiety, and anger may also be present, but all stem from the same issue—a desire for social acceptance and a fear of rejection. Most often, they maintain a social distance to avoid any further rejection. They are devastated by perceived signs of disapproval and tend to withdraw, thus reducing their chances of enhancing relationships. This circumstance results in social isolation despite a very strong need for social relatedness. These patients can put on a pleasant appearance to mask their underlying social anxiety, but they have a pervasive belief that others will be disparaging of them. Their essential conflict is a strong desire to relate but an equally strong expectation of disapproval, depreciation, and rejection. This conflict results in keeping others at a distance but also results in loneliness, isolation, and continued shyness and timidity. They are at risk for social phobias.

Millon has subtyped the avoidant personality disorder into four variants, reflecting more central personality difficulties within his domain model. Patients with a 2AP code closely resemble the hypersensitive avoidant type. This subtype retains the essential core features of the avoidant combined with more pervasive features of the paranoid personality style. The essential core feature of these patients is a pervasive apprehensiveness that people will be rejecting. The behavior of these patients is associated with an apathetic demeanor but also intense anger, fear, and resentment that may erupt in negative outbursts. These patients are easily threatened and use angry outbursts or an edgy demeanor to guard against anticipated rejection.

Diagnosis: avoidant personality disorder

2B2A

Patients with a 2B2A code are generally gloomy, pessimistic, overly serious, quiet, passive, and preoccupied with negative events. They 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 seem to find fault in even the most joyous experience. They 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 life because their incessant pessimism leads them toward a defeatist outlook. Their depressive demeanor often makes others around them feel guilty, because these patients are overly dependent on others for support and acceptance. They have difficulty expressing anger and aggression and perhaps introject it onto themselves. Interestingly, although their mood is often one of dejection and their cognitions are often dominated by negative thoughts, they do not consider themselves depressed.

This personality style is present even in the absence of 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 issues of loss.

Millon has subdivided the depressive personality disorder into five subtypes. These patients closely resemble the restive depressive subtype. Patients with a 2B2A code retain the essential features of the depressive personality style and have features of the avoidant personality style. The essential feature of this personality subtype is an agitated depression, vacillating between depressive despair and agitated anguish. These patients feel both shamed and helpless but turn their irritability and fears of rejection onto themselves. Unconsciously, their behavior is designed to elicit sympathy, support, nurturance, and reassurance from significant others.

Diagnosis: personality disorder not otherwise specified (NOS), depressive personality traits

Caution: Should these patients be clinically depressed (see page 186, Scales D, and CC, page 188), the personality profile described here may be a manifestation of depression and not their basic personality style. If this is true, then the symptoms and behaviors should abate when the depression has been successfully treated.

2B3

Patients with a 2B3 code are generally gloomy, pessimistic, overly serious, quiet, passive, and preoccupied with negative events. They 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 seem to find fault in even the most joyous experience. They 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 life because their incessant pessimism leads them toward a defeatist outlook. Their depressive demeanor often makes others around them feel guilty, because these patients are overly dependent on others for support and acceptance. They have difficulty expressing anger and aggression and perhaps introject it onto themselves. Interestingly, although their mood is often one of dejection and their cognitions are often dominated by negative thoughts, they do not consider themselves depressed.

This personality style is present even in the absence of 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 issues of loss.

Millon has subdivided the depressive personality disorder into five subtypes. Patients with a 2B3 code closely resemble the morbid depressive subtype. They retain the essential features of the depressive personality style and have features of the dependent personality style. The essential features of these patients are their pervasive dejection, despondency, hopelessness, and despairing demeanor. They often have sleep disorders, a downcast physical appearance, and near-continuous depressive conditions. More than any other depressive subtype, this personality style can easily evolve into a clinical depression. Unconsciously, their behavior is designed to elicit sympathy, support, nurturance, and reassurance from significant others.

Caution: Should these patients be clinically depressed (see Scales D, page 186, and CC, page 188), the personality profile described here may be a manifestation of depression and not their basic personality style. If this is true, then the symptoms and behaviors should abate when the depression has been successfully treated.

Diagnosis: personality disorder not otherwise specified (NOS), depressive personality traits

2B4 or 2B5

Patients with a 2B4 or 2B5 code are generally gloomy, pessimistic, overly serious, quiet, passive, and preoccupied with negative events. They 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 seem to find fault in even the most joyous experience. They 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 life because their incessant pessimism leads them toward a defeatist outlook. Their depressive demeanor often makes others around them feel guilty, because these patients are overly dependent on others for support and acceptance. They have difficulty expressing anger and aggression and perhaps introject it onto themselves. Interestingly, although their mood is often one of dejection and their cognitions are often dominated by negative thoughts, they do not consider themselves depressed.

This personality style is present even in the absence of clinical depression. These patients' 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 issues of loss.

Millon has subdivided the depressive personality disorder into five subtypes. Patients with a code 2B4 or 2B5 closely resemble the voguish depressive subtype. They retain the essential features of the depressive personality style and have features of the histrionic or narcissistic personality styles. These patients tend to adopt contemporary causes, particularly those of alienated subgroups, which allows them to ennoble their suffering and to identify with the larger subgroup, thereby allowing them to feel special. Even though they continue to

feel lonely and unattached, their identification with socially unpopular movements provides them with a form of social attachment and a vehicle to express their disenchantment and unhappiness in a socially approved manner. Unconsciously, their behavior is designed to elicit sympathy, support, nurturance, and reassurance from significant others. This style may also emanate from a narcissistic injury that has resulted in primarily depressive features. A more thorough clinical evaluation is recommended.

Caution: Should these patients be clinically depressed (see Scales D, page 186, and CC, page 188), the personality profile described here may be a manifestation of depression and not their basic personality style. If this is true then the symptoms and behaviors should abate when the depression has been successfully treated.

Diagnosis: Personality Disorder not otherwise specified (NOS), depressive personality traits

2B8A

Patients with a 2B8A code are generally gloomy, pessimistic, overly serious, quiet, passive, and preoccupied with negative events. They 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 seem to find fault in even the most joyous experience. They 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 life because their incessant pessimism leads them toward a defeatist outlook. Their depressive demeanor often makes others around them feel guilty, because these patients are overly dependent on others for support and acceptance. They have difficulty expressing anger and aggression and perhaps introject it onto themselves. Interestingly, although their mood is often one of dejection and their cognitions are often dominated by negative thoughts, they do not consider themselves to be depressed.

This personality style is present even in the absence of clinical depression. These patients' 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 issues of loss.

Millon has subdivided the depressive personality disorder into five subtypes. Patients with a 2B8A code closely resemble the ill-humored depressive subtype. They retain the essential features of the depressive personality style and have features of the passive-aggressive (negativistic) personality style. These patients have difficulty finding pleasure in any activity and spend time grumbling and complaining about their sorry state in life. They appear irritable, sour, bitter, resentful, discontented, critical, and constantly dissatisfied. Unconsciously, their behavior is designed to elicit sympathy, support, nurturance, and reassurance from significant others.

Diagnosis: personality disorder not otherwise specified (NOS), depressive personality traits

Caution: Should these patients be clinically depressed (see Scale D, page 186, and CC, page 188), the personality profile described here may be a manifestation of depression and not their basic personality style. If this is true, then the symptoms and behaviors should abate when the depression has been successfully treated.

2B8B

Patients with a 2B8B code are generally gloomy, pessimistic, overly serious, quiet, passive, and preoccupied with negative events. They 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 seem to find fault in even the most joyous experience. They 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 life because their incessant pessimism leads them toward a defeatist

outlook. Their depressive demeanor often makes others around them feel guilty, because these patients are overly dependent on others for support and acceptance. They have difficulty expressing anger and aggression and perhaps introject it onto themselves. Interestingly, although their mood is often one of dejection and their cognitions are often dominated by negative thoughts, they do not consider themselves to be depressed.

This personality style is present even in the absence of clinical depression. These patients' 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 issues of loss.

Millon has subdivided the depressive personality disorder into five subtypes. Patients with a 2B8B code closely resemble the self-derogatory depressive subtype. These patients retain the essential features of the depressive personality style and have features of the self-defeating (masochistic) personality style. These patients essentially express their anger, discontentment, and resentment in the form of self-derogatory statements and expressions of guilt that are unconsciously designed to elicit support and reassurance. Underneath such expressions is a fear of abandonment. Circumstances of perceived overburdened responsibilities are likely to exacerbate these behaviors.

Caution: Should these patients have a clinical depression (see Scales D, page 186, and CC, page 188), the personality profile described here may be a manifestation of depression and not their basic personality style. If this is true, then the symptoms and behaviors should abate when the depression has been successfully treated.

Diagnosis: personality disorder not otherwise specified (NOS), depressive personality traits

31

Millon has subdivided the dependent personality disorder into five subtypes. Patients with a 31 code closely resemble the ineffectual dependent subtype. They retain the essential features of the dependent personality and have the features of the schizoid personality.

The cardinal feature of these patients is a desire to avoid all demands and adult responsibilities that in any way would suggest independence and autonomy. Social withdrawal, communication deficits, absence of true intimate relationships, and avoidance of independent actions can be expected from them. The core motivation for the dependent personality is to obtain and maintain nurturing and supportive relationships. It is quite possible that a person can act both passively and assertively to accomplish this central goal. It has been theorized that some form of overprotection during childhood produces this style, in that these patients were not given the opportunity to learn autonomous behaviors.

Diagnosis: dependent personality disorder

32A

Patients with a 32A code tend to lean on other people for security, support, guidance, and direction. Such patients are passive, submissive, dependent, and self-conscious and lack initiative, confidence, and autonomy. Their temperament is pacifying and they try to avoid conflict. They acquiesce to maintain nurturance, affection, protection, and security. They can be expected to be obliging, docile, and placating, and they seek relationships in which they can lean on others for emotional support. They have excessive needs both for attachment and to be taken care of, and they feel helpless when alone. They willingly submit to the wishes of others to maintain this security, and this behavior tends to elicit helping and nurturing behaviors in those around them. When threatened with a loss of security, they seek out other relationships or institutions to take care of them. Their basic conflict is a fear of abandonment. This fear leads them to be overly compliant to ensure themselves of enduring protection. Their need for support is overwhelming. They prefer the dependent state and are genuinely docile. They have a self-image as a weak and fragile person, avoiding responsibilities and thereby precluding any chance of autonomy. When stressed (with a disruption of security), they are prone to develop anxiety and depressive disorders and substance abuse problems.

Millon has subdivided the dependent personality disorder into five types. Patients with a 32A code closely resemble the disquieted dependent subtype. They retain the essential features of the dependent personality and have features of the avoidant personality. The cardinal features of these patients are a combination of dependent traits plus a pervasive sense of apprehension, tension, and a constant fear of rejection and abandonment. They cling to supportive authority or to institutions, lest they be totally abandoned. Hostility toward those on whom they depend is suppressed lest they experience rejection or loss of support. The intrapsychic struggle to suppress hostility and cling to supportive structures in the face of a desire for independence and yet a fear of rejection should they demonstrate assertive behaviors accounts for their restless demeanor. It can be expected, though, that their social anxiety will be sufficiently controlled so they will lean on institutions or others to take care of them.

The core motivation for the dependent personality is to obtain and maintain nurturing and supportive relationships. It is quite possible that these patients can act both passively and assertively to accomplish this central goal.

It has been theorized that some form of overprotection during childhood produces this style, in that these patients were not given the opportunity to learn autonomous behaviors.

Diagnosis: dependent personality disorder

3′

Patients with a 3′ code tend to lean on other people for security, support, guidance, and direction. Such patients are passive, submissive, dependent, and self-conscious and lack initiative, confidence, and autonomy. Their temperament is pacifying and they try to avoid conflict. They acquiesce to maintain nurturance, affection, protection, and security. They can be expected to be obliging, docile, and placating, and they seek relationships in which they can lean on others for emotional support. They have excessive needs both for attachment and to be taken care of, and they feel helpless when alone. They willingly submit to the wishes of others to maintain this security, and

this behavior tends to elicit helping and nurturing behaviors in those around them. When threatened with a loss of security, they seek out other relationships or institutions to take care of them. Their basic conflict is a fear of abandonment. This fear leads them to be overly compliant to ensure themselves enduring protection. Their need for support is overwhelming. They prefer the dependent state and are genuinely docile. They have a self-image as a weak and fragile person, avoiding responsibilities and thereby precluding any chance of autonomy. When stressed (with a disruption of security), they are prone to develop anxiety and depressive disorders and substance abuse problems.

Millon has subdivided the dependent personality disorder into five types. Patients with a 3′ code closely resemble the accommodating dependent subtype. They retain the essential features of the dependent personality and have features of the histrionic personality. Cardinal features of these patients are their accommodating, placating, obliging, and conciliatory behaviors exhibited to avoid conflict, rejection, loss, and abandonment. They subsume their own personal identity under that of those who meet their dependency needs. They act in an inferior manner so others may dominate them and provide them with security, but at the price of their own autonomy. They tend to focus on and cater to the wishes and needs of others, suppressing their felt resentments or disillusionment to maintain their support and approval.

The core motivation for the dependent personality is to obtain and maintain nurturing and supportive relationships. It is quite possible that these patients can act both passively and assertively to accomplish this central goal.

It has been theorized that some form of overprotection during childhood produces this style, in that these patients were not given the opportunity to learn autonomous behaviors.

Diagnosis: dependent personality

38B

Patients with a 38B code tend to lean on other people for security, support, guidance, and direction. Such patients are passive, submissive, dependent, and self-conscious and lack initiative, confidence, and autonomy. Their temperament is pacifying and they try to avoid conflict. They acquiesce to maintain nurturance, affection, protection, and security. They can be expected to be obliging, docile, and placating, and they seek relationships in which they can lean on others for emotional support. They have excessive needs for both attachment and to be taken care of, and they feel helpless when alone. They willingly submit to the wishes of others to maintain this security, and this behavior tends to elicit helping and nurturing behaviors in those around them. When threatened with a loss of security, they seek out other relationships or institutions to take care of them. Their basic conflict is a fear of abandonment. This fear leads them to be overly compliant to ensure themselves enduring protection. Their need for support is overwhelming. They prefer the dependent state and are genuinely docile. They have a self-image as a weak and fragile person, avoiding responsibilities and thereby precluding any chance of autonomy. When stressed (with a disruption of security), they are prone to develop anxiety and depressive disorders and substance abuse problems.

Millon has subdivided the dependent personality disorder into five types. Patients with a 38B code closely resemble the selfless dependent subtype. They retain the essential features of the dependent personality and have features of the self-defeating personality. The cardinal feature of these patients is their willingness to submerge their own identity so that it appears as fused with the accomplishments of a significant other. Their own sense of self comes from values and deeds of the cathected object. This provides them with a sense of self-esteem, security, and stability.

The core motivation for the dependent personality is to obtain and maintain nurturing and supportive relationships. It is quite possible that these patients can act both passively and assertively to accomplish this central goal.

It has been theorized that some form of overprotection during childhood produces this style, in that these patients were not given the opportunity to learn autonomous behaviors.

Diagnosis: dependent personality disorder

43

Expect patients with a 43 code to be overly dramatic, with strong needs to be the center of attention. Such patients are seductive, through speech, style, dress, or manner, and seek constant stimulation and excitement in an exhibitionistic atmosphere; they require praise and attention. They are emotionally labile, are easily excited, and have frequent emotional outbursts. They are very gregarious, assertive, and socially outgoing, but they manipulate people to draw their approval and affection. They have strong needs for constant social acceptance. They are socially facile and seductively engaging, such that others are drawn to their enchanting manner. Relationships are often shallow and strained, however, as a result of their repeatedly dramatic and emotional outbursts and their self-centeredness. Denial and repression are their main defenses. They court the favor of others, but beneath this confident and self-assured persona is a fear of autonomy and independence that requires constant acceptance and approval to keep it in abeyance. They tend to displace anxieties when stressed. They are at risk for somatoform disorders and marital problems.

Millon has subdivided the histrionic personality disorder into six subtypes. Patients with a 43 code closely resemble the appeasing histrionic subtype. They retain the essential features of the histrionic personality and have features of the dependent personality. The cardinal feature of these patients is their unrelenting desire to please other people. Their main goal is not to seek attention but rather approval. They would do almost anything to placate valued others, largely because of a self-image that they are inadequate and unlovable. This latter aspect is largely unconscious. Millon has theorized that this subtype represents a transferential pattern whereby repressed hostility felt toward an unpleasant childhood caretaker (usually a parent) is projected yet denied on to a symbolic object. Through reaction formation, these patients believe using an excessively conciliatory manner is necessary to gain approval.

Caution: Empirical research has shown that Scale 4 (1) correlates positively with measures of mental health and negatively with measures of mental disorders; (2) infrequently appears in MCMI code types in psychiatric patients, except for substance abuse; and (3) is frequently the scale with the most elevated scores among nonclinical patients who have taken this test, particularly among women. These people would have a gregarious, extroverted, and socially engaging personality style but not a histrionic disorder. The clinician needs to evaluate which of these two possibilities is applicable to the particular patient.

Diagnosis: histrionic personality disorder

45

Expect patients with a 45 code to be overly dramatic and have strong needs to be the center of attention. Such patients are seductive, through speech, style, dress, or manner, and seek constant stimulation and excitement in an exhibitionistic atmosphere; they require praise and attention. They are emotionally labile, are easily excited, and have frequent emotional outbursts. They are very gregarious, assertive, and socially outgoing, but they manipulate people to draw their approval and affection. They have strong needs for constant social acceptance. They are socially facile and seductively engaging, such that others are drawn to their enchanting manner. Relationships are often shallow and strained, however, as a result of their repeatedly dramatic and emotional outbursts and their self-centeredness. Denial and repression are their main defenses. They court the favor of others, but beneath this confident and self-assured persona is a fear of autonomy and independence that requires constant acceptance and approval to keep it in abeyance. They tend to displace anxieties when stressed. They are at risk for somatoform disorders and marital problems.

Millon has subdivided the histrionic personality disorder into six subtypes. Patients with a 45 code closely resemble the vivacious histrionic subtype. They retain the essential features of the histrionic personality and have features of the narcissistic personality. The cardinal features of this subtype are a hypomanic-like level of energy, enthusiasm, buoyancy, and flamboyance, combined with easy excitability,

impulsiveness, and vivacious playfulness. They show many narcissistic traits and are quite animated. However, they retain the excessive need for attention and approval that is characteristic of the histrionic style and remain superficial and unaware of the effect of their behaviors on others.

Caution: Empirical research has shown that Scale 4 (1) correlates positively with measures of mental health and negatively with measures of mental disorders; (2) infrequently appears in MCMI code types in psychiatric patients, except for substance abuse; and (3) is frequently the scale with the most elevated scores among nonclinical patients who have taken this test, particularly among women. These people would have a gregarious, extroverted, and socially engaging personality style but not a histrionic disorder. The clinician needs to evaluate which of these two possibilities is applicable to the particular patient.

Diagnosis: histrionic personality disorder

46A

Expect patients with a 46A code to be overly dramatic, with strong needs to be the center of attention. Such patients are seductive, through speech, style, dress, or manner, and seek constant stimulation and excitement in an exhibitionistic atmosphere; they require praise and attention. They are emotionally labile, are easily excited, and have frequent emotional outbursts. They are very gregarious, assertive, and socially outgoing, but they manipulate people to draw their approval and affection. They have strong needs for constant social acceptance. They are socially facile and seductively engaging, such that others are drawn to their enchanting manner. Relationships are often shallow and strained, however, as a result of their repeatedly dramatic and emotional outbursts and their self-centeredness. Denial and repression are their main defenses. They court the favor of others, but beneath this confident and self-assured persona is a fear of autonomy and independence that requires constant acceptance and approval to keep it in abeyance. They tend to displace anxieties when stressed. They are at risk for somatoform disorders and marital problems.

Millon has subdivided the histrionic personality disorder into six subtypes. Patients with a 46A code closely resemble the disingenuous histrionic subtype. They retain the essential features of the histrionic personality and have features of the antisocial personality. The cardinal feature of these patients is their shallow, superficial interpersonal relationships. They are insincere, unreliable, calculating, and deceitful, despite their superficial charm and overt friendliness. Their basic defenses are denial, repression, rationalization, and externalization. They are quite egocentric and hedonistic and basically insincere in their relationships. Unconsciously, they believe they are unlovable, so they act in ways to force others to love them. These patients are easily provoked and may react vindictively.

Caution: Empirical research has shown that Scale 4 (1) correlates positively with measures of mental health and negatively with measures of mental disorders; (2) infrequently appears in MCMI code types in psychiatric patients, except for substance abuse; and (3) is frequently the scale with the most elevated scores among nonclinical patients who have taken this test, particularly among women. These people would have a gregarious, extroverted, and socially engaging personality style but not a histrionic disorder. The clinician needs to evaluate which of these two possibilities is applicable to the particular patient.

Diagnosis: histrionic personality disorder

48A

Expect patients with a 48A code to be overly dramatic, with strong needs to be the center of attention. Such patients are seductive, through speech, style, dress, or manner, and seek constant stimulation and excitement in an exhibitionistic atmosphere; they require praise and attention. They are emotionally labile, are easily excited, and have frequent emotional outbursts. They are very gregarious, assertive, and socially outgoing, but they manipulate people to draw their approval and affection. They have strong needs for constant social acceptance. They are socially facile and seductively engaging, such that others are drawn to their enchanting manner. Relationships are

often shallow and strained, however, as a result of their repeatedly dramatic and emotional outbursts and their self-centeredness. Denial and repression are their main defenses. They court the favor of others, but beneath this confident and self-assured persona is a fear of autonomy and independence that requires constant acceptance and approval to keep it in abeyance. They tend to displace anxieties when stressed. They are at risk for somatoform disorders and marital problems.

Millon has subdivided the histrionic personality disorder into six subtypes. Patients with a 48A code closely resemble the tempestuous histrionic subtype. They retain the essential features of the histrionic personality and have features of the passive-aggressive (negativistic) personality. The cardinal features of these patients is their turbulent emotional expressiveness, which is reactive to minor provocations. This emotional lability and their impulsive acting-out behaviors comingle with a petulant, moody, querulous, and brooding demeanor that results in ephemeral displays of anger followed by a return to their basic histrionic style.

Caution: Empirical research has shown that Scale 4 (1) correlates positively with measures of mental health and negatively with measures of mental disorders; (2) infrequently appears in MCMI code types in psychiatric patients, except for substance abuse; and (3) is frequently the scale with the most elevated scores among nonclinical patients who have taken this test, particularly among women. These people would have a gregarious, extroverted, and socially engaging personality style but not a histrionic disorder. The clinician needs to evaluate which of these two possibilities is applicable to the particular patient.

Diagnosis: histrionic personality disorder

4C

Expect patients with a 4C code to be overly dramatic, with strong needs to be the center of attention. Such patients are seductive, through speech, style, dress, or manner, and seek constant stimulation and excitement in an exhibitionistic atmosphere; they require praise and attention. They are emotionally labile, are easily excited, and

have frequent emotional outbursts. They are very gregarious, assertive, and socially outgoing, but they manipulate people to draw their approval and affection. They have strong needs for constant social acceptance. They are socially facile and seductively engaging, such that others are drawn to their enchanting manner. Relationships are often shallow and strained, however, as a result of their repeatedly dramatic and emotional outbursts and their self-centeredness. Denial and repression are their main defenses. They court the favor of others, but beneath this confident and self-assured persona is a fear of autonomy and independence that requires constant acceptance and approval to keep it in abeyance. They tend to displace anxieties when stressed. They are at risk for somatoform disorders and marital problems.

Millon has subdivided the histrionic personality disorder into six subtypes. Patients with a 4C code closely resemble the infantile histrionic subtype. They retain the essential features of the histrionic personality and have features of the borderline personality style. The cardinal feature of these patients is their erratic emotionality, characterized by labile and volatile emotional expression. They behave in very childlike ways (e.g., pouting, clinging, demanding) and they are overly attached to a strong figure.

Caution: Empirical research has shown that Scale 4 (1) correlates positively with measures of mental health and negatively with measures of mental disorders; (2) infrequently appears in MCMI code types in psychiatric patients, except for substance abuse; and (3) is frequently the code with the most elevated scores among nonclinical patients who have taken this test, particularly among women. These people would have a gregarious, extroverted, and socially engaging personality style but not a histrionic disorder. The clinician needs to evaluate which of these two possibilities is applicable with the particular patient.

Diagnosis: histrionic personality disorder

54

Patients with a 54 code are quite self-centered and expect people to recognize their special qualities, and they require constant praise and

recognition. They have excessive entitlement expectations and demand special favors. Grandiose statements of self-importance are readily elicited, and they consider themselves particularly attractive. They appear egocentric, arrogant, haughty, conceited, boastful, snobbish, pretentious, and supercilious. They exploit people and manipulate them with an air of superiority. Although they can be momentarily charming, they have a deficient social conscience and think only of themselves. They show a social imperturbability and are likely to disregard social constraints. They exploit social relationships, are indifferent to the rights of others, relate in an autocratic manner, and expect others to focus on them. Although this basic style often alienates other people, they respond with a sense of contempt and indifference because their inflated sense of self needs no confirmation from other people. They are quite grandiose and arrogant and rarely show signs of self-doubt. If they are humiliated or experience a narcissistic injury, they are prone to develop an affective disorder and perhaps a paranoid disorder. Many substance abusers also have a narcissistic personality style.

Millon has subdivided the narcissistic personality disorder into four subtypes. Patients with a 54 code closely resemble the amorous narcissistic subtype. They retain the essential features of the narcissistic personality and have features of the histrionic personality. The cardinal features of these patients are their sexual seductiveness and desire for sexual conquest to demonstrate their self-worth. These patients resort to lying, sexual bantering, sexual excesses, and fraud and use any means to attain sexual dominance. Their self-worth seems to emanate from their ability to beguile others with their clever charm, air of superiority, self-confidence, and boastful exploits. Their relationships tend to be brief, as they need to begin the process over and over again. Unconsciously, the amorous narcissist probably has feelings of inadequacy and low self-worth.

Caution: Empirical research has shown that Scale 5 (1) correlates positively with measures of mental health and negatively with measures of mental disorders; (2) infrequently appears in MCMI code types in psychiatric patients, except for substance abuse; and (3) is frequently the scale with the most elevated scores among nonclinical

patients who have taken this test, particularly among women. These people would have a confident demeanor with high self-regard and seem socially charming and perhaps even attention seeking as a personality style but do not have a narcissistic personality disorder. The clinician needs to evaluate which of these two possibilities is applicable to the particular patient.

Diagnosis: narcissistic personality disorder

56A

Patients with a 56A code are quite self-centered, expect people to recognize their special qualities, and require constant praise and recognition. They have excessive entitlement expectations and demand special favors. Grandiose statements of self-importance are readily elicited, and they consider themselves particularly attractive. They appear egocentric, arrogant, haughty, conceited, boastful, snobbish, pretentious, and supercilious. They exploit people and manipulate them with an air of superiority. Although they can be momentarily charming, they have a deficient social conscience and think only of themselves. They show a social imperturbability and are likely to disregard social constraints. They exploit social relationships, are indifferent to the rights of others, relate in an autocratic manner, and expect others to focus on them. Even though this basic style often alienates other people, they respond with a sense of contempt and indifference because their inflated sense of self needs no confirmation from other people. They are quite grandiose and arrogant and rarely show signs of self-doubt. If they are humiliated or experience a narcissistic injury, they are prone to develop an affective disorder and perhaps a paranoid disorder. Many substance abusers also have a narcissistic personality style.

Millon has subdivided the narcissistic personality disorder into four subtypes. Patients with a 56A code closely resemble the unprincipled narcissistic subtype. They retain the essential features of the narcissistic personality and have features of the antisocial personality. The cardinal features of these patients is their defective superego, demonstrated as antisocial behaviors and traits. They maintain rela-

tionships only when it is to their benefit. They have no sense of loyalty and no social conscience, so they are indifferent to the welfare of others and willingly exploit them. They tend to react impulsively when provoked. They may live on the edge of the law or flaunt the law, believing they are above it. They are replete with deceit, vindictiveness, and malice projected onto those they hold responsible for their annoyances. Their demeanor is one of arrogant disregard and they project an air of intimidation. They maintain a cool appearance and seem defiant in the face of threats or punishment. They are at extreme risk for legal problems, vocational problems, substance abuse, and marital disruptions.

Caution: Empirical research has shown that Scale 5 (1) correlates positively with measures of mental health and negatively with measures of mental disorders; (2) infrequently appears in MCMI code types in psychiatric patients, except for substance abuse; and (3) is frequently the scale with the most elevated scores among nonclinical patients who have taken this test, particularly among men. These people would have a confident demeanor with high self-regard and seem socially charming and perhaps even attention seeking as a personality style but they do not have a narcissistic personality disorder. The clinician needs to evaluate which of these two possibilities is applicable to the particular patient.

Diagnosis: narcissistic personality disorder, antisocial personality disorder, or both

58A or 52A

Patients with a 58A or 52A code are quite self-centered, expect people to recognize their special qualities, and require constant praise and recognition. They have excessive entitlement expectations and demand special favors. Grandiose statements of self-importance are readily elicited, and they consider themselves particularly attractive. They appear egocentric, arrogant, haughty, conceited, boastful, snobbish, pretentious, and supercilious. They exploit people and manipulate them with an air of superiority. Although they can be momentarily charming, they have a deficient social conscience and think only of themselves. They show a social imperturbability and are likely to disregard social constraints. They exploit social relationships, are indifferent to the rights of others, relate in an autocratic manner, and expect others to focus on them. Even though this basic style often alienates other people, they respond with a sense of contempt and indifference because their inflated sense of self needs no confirmation from other people. They are quite grandiose and arrogant and rarely show signs of self-doubt. If they are humiliated or experience a narcissistic injury, they are prone to develop an affective disorder and perhaps a paranoid disorder. Many substance abusers also have a narcissistic personality style.

Millon has subdivided the narcissistic personality disorder into four subtypes. Patients with a 58A or 52A code closely resemble the compensating narcissistic subtype. They retain the essential features of the narcissistic personality and have features of the passive-aggressive (negativistic) or avoidant personality styles. The cardinal feature of these patients is their strong desire to be seen as confident, superior, and worthy of worship, which derives from an underlying sense of insecurity and lack of self-esteem. They are attempting to compensate for early-life psychological deprivations by striving for prestige and enhancing their fragile sense of self. They live in fear that others will discover they are a fraud.

Caution: Empirical research has shown that Scale 5 (1) correlates positively with measures of mental health and negatively with measures of mental disorders; (2) infrequently appears in MCMI code types in psychiatric patients, except for substance abuse; and (3) is frequently the scale with the most elevated scores among nonclinical patients who have taken this test, particularly among men. These people would have a confident demeanor with high self-regard and seem socially charming and perhaps even attention seeking as a personality style, but they do not have a narcissistic personality disorder. The clinician needs to evaluate which of these two possibilities is applicable to the particular patient.

Diagnosis: narcissistic personality disorder

6A1 or 6A2A

Patients with a 6A1 or 6A2A code are quite narcissistic, fearless, pugnacious, daring, blunt, aggressive and assertive, irresponsible, impulsive, ruthless, victimizing, intimidating, and dominating; often are energetic and competitive; and are quite determined and independent. They are argumentative, self-reliant, revengeful, and vindictive. They are chronically dissatisfied and harbor resentments toward people who challenge, criticize, or express disapproval of their behavior. They are characteristically touchy and jealous, brood over perceived slights and wrongs, and provoke fear in those around them through their intimidating social demeanor. They tend to present with an angry, hostile affect. They are suspicious and skeptical of the motives of other people, plan revenge for past grievances, and view others as untrustworthy. They avoid expressions of warmth, gentleness, closeness, and intimacy, viewing such involvements as a sign of weakness. They 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 others for self-gain. These patients are driven by power, by malevolent projections, and by an expectation of suffering at the hands of 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 to substance abuse, relationship difficulties, vocational deficits, and legal problems.

Millon has subdivided the antisocial personality disorder into five types. Patients with a 6A1 or 6A2A code closely resemble the nomadic antisocial subtype. They have the features of the antisocial personality with those of the schizoid or avoidant personality styles. These patients are generally indifferent and disengaged from social

responsibilities. They go through life remaining on the periphery of social roles, and they socially withdraw to mask their intense feelings of anger and resentment. In a psychoanalytic sense, their nomadic existence may symbolically represent a search for a home and for parental love and acceptance, which they feel have been missing in their lives. They feel that society has been unjust to them and they therefore distance themselves from the possibilities of continued further disappointments. These patients are comparatively more benign than other antisocial subtypes but remain asocial and angry over their "abandoned" status. Other people would describe them as loners.

Many drug addicts have tested as having this pattern on the MCMI-III. In those instances in which patients have not had a nomadic pattern, their Scale 1 spike may suggest an emotionally detached personality with a self-imposed withdrawal and isolating behavior to bind anxiety. However, when stressed, they are prone to erupt in antisocial behavior.

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

Diagnosis: antisocial personality disorder

6A4

Patients with a 6A4 code are quite narcissistic, fearless, pugnacious, daring, blunt, aggressive and assertive, irresponsible, impulsive, ruthless, victimizing, intimidating, and dominating; are often energetic and competitive; and are quite determined and independent. They are argumentative, self-reliant, revengeful, and vindictive. They are chronically dissatisfied and harbor resentments against people who challenge, criticize, or express disapproval of their behavior. They are characteristically touchy and jealous, brood over perceived slights and wrongs, and provoke fear in those around them through their intimidating social demeanor. They tend to present with an angry and hostile affect. They are suspicious and skeptical of the motives of other people, plan revenge for past grievances, and view others as untrustworthy. They avoid expressions of warmth, gentleness, closeness, and intimacy, viewing such involvements as a sign of weakness. They 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 others for self-gain. These patients are driven by power, by malevolent projections, and by an expectation of suffering at the hands of 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 to substance abuse, relationship difficulties, vocational deficits, and legal problems.

Millon has subdivided the antisocial personality disorder into five types. Patients with a 6A4 code closely resemble the risk-taking antisocial type. They retain the essential features of the antisocial personality and have features of the histrionic personality. The cardinal feature of these patients is their desire for adventure, stimulation, danger, and perilous activity. This desire is motivated by a feeling of being trapped by routinized tasks and by daily responsibilities. These patients are sensation seekers who appear fun loving but are quite unreliable and undependable and possess essentially antisocial personality traits.

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

Diagnosis: antisocial personality disorder

6A5

Patients with a 6A5 code are quite narcissistic, fearless, pugnacious, daring, blunt, aggressive and assertive, irresponsible, impulsive, ruthless, victimizing, intimidating, and dominating; are often energetic and competitive; and are quite determined and independent. They are argumentative, self-reliant, revengeful, and vindictive. They are chronically dissatisfied and harbor resentments against people who challenge, criticize, or express disapproval over their behavior. They

are characteristically touchy and jealous, brood over perceived slights and wrongs, and provoke fear in those around them through their intimidating social demeanor. They tend to present with an angry, hostile affect. They are suspicious and skeptical of the motives of other people, plan revenge for past grievances, and view others as untrustworthy. They avoid expressions of warmth, gentleness, closeness, and intimacy, viewing such involvements as a sign of weakness. They 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 others for self-gain. These patients are driven by power, by malevolent projections, and by an expectation of suffering at the hands of 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 to substance abuse, relationship difficulties, vocational deficits, and legal problems.

Millon has subdivided the antisocial personality disorder into five types. Patients with a 6A5 code closely resemble the reputation-defending antisocial type. They retain the essential features of the antisocial personality and have features of the narcissistic personality. The cardinal feature of these patients is their desire to maintain an image and reputation as a tough, aggressive, and mean-spirited person. Their personality style provides them with group status and usually a position of authority and leadership within a deviant subgroup. They are quick to attack and assail anyone or anything that threatens their status. They need to be seen as strong and as a person not to be "messed with."

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

Diagnosis: antisocial personality disorder

6A6B or 6AP

Patients with a 6A6B or 6AP code are quite narcissistic, fearless, pugnacious, daring, blunt, aggressive and assertive, irresponsible, impulsive, ruthless, victimizing, intimidating, and dominating; are often energetic and competitive; and are quite determined and independent. They are argumentative, self-reliant, revengeful, and vindictive. They are chronically dissatisfied and harbor resentments against people that challenge, criticize, or express disapproval of their behavior. They are characteristically touchy and jealous, brood over perceived slights and wrongs, and provoke fear in those around them through their intimidating social demeanor. They tend to present with an angry, hostile affect. They are suspicious and skeptical of the motives of other people, plan revenge for past grievances, and view others as untrustworthy. They avoid expressions of warmth, gentleness, closeness, and intimacy, viewing such involvements as a sign of weakness. They 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 others for self-gain. These patients are driven by power, by malevolent projections, and by an expectation of suffering at the hands of 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 to substance abuse, relationship difficulties, vocational deficits, and legal problems.

Millon has subdivided the antisocial personality disorder into five types. Patients with a 6A6B or 6AP code closely resemble the malevolent antisocial type. They retain the essential features of the antisocial personality and have features of the aggressive/sadistic or paranoid personality styles. The cardinal features of these patients are their particularly evil intentions and behavior. These patients are

especially hostile, vindictive, belligerent, aggressive, brutal, and resentful. They distrust others, anticipate punishment from them, and react with cold retaliation. They show or feel little guilt or remorse for any of their actions. They maintain an image of strength, power, and dominance.

Diagnosis: antisocial personality disorder

6B2A

Patients with a 6B2A code may not be publicly antisocial, but their clinical features are quite similar to those of the antisocial personality and the style may be considered as a more pathological variant of the antisocial style. They engage in behaviors that are abusive and humiliating and may violate the rights and feelings of others. They are aggressive, forceful, commanding, militant, domineering, hardheaded, hostile, dominating, intimidating, pervasively destructive, and brutal. They become combative when provoked, and they are antagonistic and disagreeable people. They tend to be touchy, excitable, and irritable and react angrily when confronted. In psychoanalytic terms, they are sadistic personalities. Some are able to sublimate these traits into socially approved vocations. When their autonomy is threatened, they are prone to spouse abuse and explosive outbursts that may result in legal problems.

Millon has subdivided the aggressive/sadistic personality disorder into four subtypes. Patients with a 6B2A code closely resemble the spineless sadist subtype. They retain the essential features of the aggressive/sadistic personality and have features of the avoidant personality. These patients show the essential prototype features of the aggressive/sadistic personality, but they do so to hide their feelings of inadequacy and fearfulness. Their aggressive behavior is counterphobic and is a reaction formation designed to hide their insecurities. They rely on group support to help them hide their weakness and they tend to pick on weaker scapegoats.

Diagnosis: personality disorder not otherwise specified (NOS), aggressive personality traits

6B7

Patients with a 6B7 code may not be publicly antisocial, but their clinical features are quite similar to those of the antisocial personality and the style may be considered as a more pathological variant of the antisocial style. They engage in behaviors that are abusive and humiliating and may violate the rights and feelings of others. They are aggressive, forceful, commanding, militant, domineering, hardheaded, hostile, dominating, intimidating, pervasively destructive, and brutal. They become combative when provoked, and they are antagonistic and disagreeable people. They tend to be touchy, excitable, and irritable and react angrily when confronted. In psychoanalytic terms, they are sadistic personalities. Some are able to sublimate these traits into socially approved vocations. When their autonomy is threatened, they are prone to spouse abuse and explosive outbursts that may result in legal problems.

Millon has subdivided the aggressive/sadistic personality disorder into four subtypes. These patients closely resemble the enforcing sadist subtype. They retain the essential features of the aggressive/sadistic personality and have features of the compulsive personality. The cardinal feature of these patients is their abuse of social power. They are often in positions of socially sanctioned roles where their responsibilities include meting out punishment. They have lost their sense of balance and rigidly apply punishment in an inhumane and self-righteous manner. They may occupy legitimate social roles (e.g., police officer) or may be engaged in illicit social roles (e.g., mob hit man).

Diagnosis: personality disorder not otherwise specified (NOS), aggressive personality traits

6B8A or 6BP

Patients with a 6B8A or 6BP code may not be publicly antisocial, but their clinical features are quite similar to those of the antisocial personality and the style may be considered as a more pathological variant of the antisocial style. They engage in behaviors that are abusive and humiliating and may violate the rights and feelings of others.

They are aggressive, forceful, commanding, militant, domineering, hardheaded, hostile, dominating, intimidating, pervasively destructive, and brutal. They become combative when provoked, and they are antagonistic and disagreeable people. They tend to be touchy, excitable, and irritable and react angrily when confronted. In psychoanalytic terms, they are sadistic personalities. Some are able to sublimate these traits into socially approved vocations. When their autonomy is threatened, they are prone to spouse abuse and explosive outbursts that may result in legal problems.

Millon has subdivided the aggressive/sadistic personality disorder into four subtypes. Patients with a 6B8A or 6BP code closely resemble the tyrannical sadist subtype. They retain the essential features of the aggressive/sadistic personality and have features of the passive-aggressive (negativistic) or paranoid personality styles. The cardinal feature of these patients is their use of violence to intimidate, terrorize, and subjugate weaker people, forcing them to cooperate and obey. These patients act in a menacing, threatening, abusing, and demeaning manner and feel satisfied with the violence they perpetrate. If these patients do not have an actual history of physical violence, then they use threats of cruelty, verbal abuse, and threats of violence to keep people in line. Millon considers this type to be one of the most frightening and cruel types of any personality disorder.

Diagnosis: personality disorder not otherwise specified (NOS), aggressive personality traits

71

Patients with a 71 code are behaviorally rigid, constricted, conscientious, polite, organized, meticulous, punctual, respectful, often perfectionistic, formal, prudent, overconforming, cooperative, compliant with rules, serious, moralistic, self-righteous and self-disciplined, efficient, and relatively inflexible. They place high demands on themselves. They are emotionally restrained, suppressing strong resentments and anger, and they appear tense and grim but emotionally controlled. They are socially conforming and prone to a repetitive lifestyle, as a result of engaging in a series of patterned behaviors

and rules that must be followed. They have fears of social disapproval and are models of propriety and restraint. They show excessive respect for authority but may treat subordinates in an autocratic manner. They operate from a sense of duty that compels them to not let others down, thus risking the condemnation of authority figures. They show an anxious conformity. They strive to avoid criticism but expect it because of what they perceive to be their personal shortcomings. They fear making mistakes because of expected disapproval. Their behavior stems from a conflict between a felt hostility that they wish to express and a fear of social disapproval should they expose this underlying oppositional resentment. This circumstance forces them to become overconforming, thus placing high demands on themselves that serve to control this intense anger, which occasionally breaks through into their behavior. Obsessive thinking may or may not be present.

Millon has subdivided the compulsive personality disorder into five subtypes. Patients with a 71 code closely resemble the parsimonious compulsive. They retain the essential features of the compulsive personality and have features of the schizoid personality. The cardinal feature of these patients is intensely tight-fisted, penny-pinching, hoarding behavior. These patients have been deprived at some point in their life and doggedly protect their possessions. They are unwilling to share. They maintain an emotional distance from people, focusing on external signs of self-worth to hide their inner sense of personal emptiness.

Caution: Empirical research has shown that (1) Scale 7 correlates positively with measures of mental health and negatively with measures of mental disorders; (2) Scale 7 infrequently appears in MCMI code types in psychiatric patients; (3) Scale 7 is frequently the scale with the most elevated scores among nonclinical patients who have taken this test, particularly among men; and (4) the only study that has used the MCMI with patients with an obsessive-compulsive disorder did not have elevated score on Scale 7. Thus, patients with elevated scores on Scale 7 would be conscientious, rule bound, and orderly, suggesting a compulsive personality style but not a compulsive

disorder. The clinician needs to evaluate which of these two possibilities is applicable to the particular patient.

Diagnosis: compulsive personality disorder

75

Patients with a 75 code are behaviorally rigid, constricted, conscientious, polite, organized, meticulous, punctual, respectful, often perfectionistic, formal, prudent, overconforming, cooperative, compliant with rules, serious, moralistic, self-righteous and self-disciplined, efficient, and relatively inflexible. They place high demands on themselves. They are emotionally restrained, suppressing strong resentments and anger, and they appear tense and grim but emotionally controlled. They are socially conforming and prone to a repetitive lifestyle as a result of engaging in a series of patterned behaviors and rules that must be followed. They have fears of social disapproval and are models of propriety and restraint. They show excessive respect for authority but may treat subordinates in an autocratic manner. They operate from a sense of duty that compels them to not let others down, thus risking the condemnation of authority figures. They show an anxious conformity. They strive to avoid criticism but expect it because of what they perceive to be their personal shortcomings. They fear making mistakes because of expected disapproval. Their behavior stems from a conflict between a felt hostility that they wish to express and a fear of social disapproval should they expose this underlying oppositional resentment. This circumstance forces them to become overconforming, thus placing high demands on themselves that serve to control this intense anger, which occasionally breaks through into their behavior. Obsessive thinking may or may nor be present.

Millon has subdivided the compulsive personality disorder into five subtypes. Patients with a 75 code closely resemble the bureaucratic compulsive. They retain the essential features of the compulsive personality and have features of the narcissistic personality. The cardinal feature of these patients is their blind obedience to values, rules,

and structure of an external authority. Adherence to rules, regulations, procedures, and instructions gives these patients a sense of security, absolves them from personal responsibility, and reduces opportunities for disapproval from authority figures. Although extremely loyal, dependable, conventional, and dedicated, they may also appear to be excessively rigid, closed-minded, and dogmatic. This style might be a transference and an effective sublimation from a rigid authority figure (parent) experienced early in life, or it could be the result of learned behavior from functioning in an extremely structured environment where roles are constantly threatened for minor mistakes.

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Diagnosis: compulsive personality disorder

78A

Patients with a 78A code are behaviorally rigid, constricted, conscientious, polite, organized, meticulous, punctual, respectful, often perfectionistic, formal, prudent, overconforming, cooperative, compliant with rules, serious, moralistic, self-righteous and self-disciplined, efficient, and relatively inflexible. They place high demands on themselves. They are emotionally restrained, suppressing strong resentments and anger, and they appear tense and grim but emotionally controlled. They are socially conforming and prone to a repetitive lifestyle as a result of engaging in a series of patterned behaviors and rules that must be followed. They have fears of social disapproval

and are a model of propriety and restraint. They show excessive respect for authority but may treat subordinates in an autocratic manner. They operate from a sense of duty that compels them to not let others down, thus risking the condemnation of authority figures. They show an anxious conformity. They strive to avoid criticism but expect it because of what they perceive to be their personal shortcomings. They fear making mistakes because of expected disapproval. Their behavior stems from a conflict between a felt hostility that they wish to express and a fear of social disapproval should they expose this underlying oppositional resentment. This circumstance forces them to become overconforming; thus they place high demands on themselves that serve to control this intense anger, which occasionally breaks through into their behavior. Obsessive thinking may or may not be present.

Millon has subdivided the compulsive personality disorder into five subtypes. Patients with a 78A code closely resemble the bedeviled compulsive. They retain the essential features of the compulsive personality and have features of the passive-aggressive (negativistic) personality. The cardinal feature of this subtype is a strong conflict between expressing oppositional tendencies and satisfying the wishes of others. This results in traits of discontentment, indecisiveness, confusion, and irritability and in a troubled inner mental life, although they may actually appear to be a paragon of rationality.

Caution: Empirical research has shown that (1) Scale 7 correlates positively with measures of mental health and negatively with measures of mental disorders; (2) Scale 7 infrequently appears in MCMI code types in psychiatric patients; (3) Scale 7 is frequently the scale with the most elevated scores among nonclinical patients who have taken this test, particularly among men; and (4) the only study that has used the MCMI with patients with an obsessive-compulsive disorder did not have elevated scores on Scale 7. Thus, patients with elevated scores on Scale 7 would be conscientious, rule bound, and orderly, suggesting a compulsive personality style but not a compulsive disorder. The clinician needs to evaluate which of these two possibilities is applicable to the particular patient.

Diagnosis: compulsive personality disorder

7P

Patients with a 7P code are behaviorally rigid, constricted, conscientious, polite, organized, meticulous, punctual, respectful, often perfectionistic, formal, prudent, overconforming, cooperative, compliant with rules, serious, moralistic, self-righteous and self-disciplined, efficient, and relatively inflexible. They place high demands on themselves. They are emotionally restrained, suppressing strong resentments and anger, and they appear tense, grim, but emotionally controlled. They are socially conforming and prone to a repetitive lifestyle as a result of engaging in a series of patterned behaviors and rules that must be followed. They have fears of social disapproval and are a model of propriety and restraint. They show excessive respect for authority but may treat subordinates in an autocratic manner. They operate from a sense of duty that compels them to not let others down, thus risking the condemnation of authority figures. They show an anxious conformity. They strive to avoid criticism but expect it because of what they perceive to be their personal shortcomings. They fear making mistakes because of expected disapproval. Their behavior stems from a conflict between a felt hostility that they wish to express and a fear of social disapproval should they expose this underlying oppositional resentment. This circumstance forces them to become overconforming; thus they place high demands on themselves that serve to control this intense anger, which occasionally breaks through into their behavior. Obsessive thinking may or may not be present.

Millon has subdivided the compulsive personality disorder into five subtypes. Patients with a 78A code closely resemble the puritanical compulsive. They retain the essential features of the compulsive personality and have features of the paranoid personality. The cardinal feature of these patients is a self-righteous distribution of morality. These patients are quite harsh, judgmental, prudish, controlled, and grim. They are anxious about making mistakes and fear humiliation. They behave as if they are responsible for redressing the sins of the world. Although not paranoid in the clinical sense, they have paranoid-like traits (e.g., being suspicious, overly judgmental, argumentative, resentful, opinionated, fault-finding, critical, and uncompromising).

Caution: Empirical research has shown that (1) Scale 7 correlates positively with measures of mental health and negatively with measures of mental disorders; (2) Scale 7 infrequently appears in MCMI code types in psychiatric patients; (3) Scale 7 is frequently the scale with the most elevated scores among nonclinical patients who have taken this test, particular among men; and (4) the only study that has used the MCMI with patients with an obsessive-compulsive disorder did not have elevated scores on Scale 7. Thus, patients with elevated scores on Scale 7 would be conscientious, rule bound, and orderly, suggesting a compulsive personality style but not a compulsive disorder. The clinician needs to evaluate which of these two possibilities is applicable to the particular patient.

Diagnosis: compulsive personality disorder

8A2B

Patients with an 8A2B code display a mixture of passive compliance and obedience at one time and oppositional and negativistic behavior at the next time. They are moody, irritable, and hostile; manifest a grumbling and pessimistic demeanor; and are erratically and explosively angry and stubborn at one moment and feel guilty and contrite at the next moment. Disillusionment seems to permeate their lives. They feel misunderstood, so they vacillate between passive dependency and stubborn contrariness, which provokes discomfort and exasperation in those around them. They expect disappointment and maintain an unstable and conflictual role in relations with others. They sulk, feel unappreciated and/or that they are being treated unfairly, constantly complain, and are persistently petulant and discontented. They often have problems with authority and, if employed, have job difficulties.

Millon has subdivided the passive-aggressive (negativistic) personality disorder into four subtypes. Patients with an 8A2B code closely resemble the discontented negativistic subtype. They retain the essential features of the passive-aggressive (negativistic) person-

ality and have features of the depressive personality. The cardinal feature of these patients is their malcontentedness. They are negativistic in the true sense of the word and are intentionally complaining, grumbling, dissatisfied, discontented, testy, moody, and disgruntled. They tend to not openly confront those who have aggrieved them; rather, they tend to try to embarrass or undercut those who have wronged them while making themselves appear righteous.

Commentary: An elevation on Scale 8A is a good indicator of problems with authority and with criminal behaviors or potential criminal behavior. Also, clinical elevations on this scale appear in a number of profile codes involving psychiatric patients. Patients with elevations on Scale 8A warrant close clinical evaluation.

Diagnosis: personality disorder not otherwise specified (NOS), passive-aggressive (negativistic) traits

8A3

Patients with an 8A3 code display a mixture of passive compliance and obedience at one time and oppositional and negativistic behavior the next time. They are moody, irritable, and hostile; manifest a grumbling and pessimistic demeanor; and are erratically and explosively angry and stubborn at one moment and feel guilty and contrite at the next moment. Disillusionment seems to permeate their lives. They feel misunderstood, so they vacillate between passive dependency and stubborn contrariness, which provokes discomfort and exasperation in those around them. They expect disappointment and maintain an unstable and conflictual role in relations with others. They sulk, feel unappreciated and/or that they are being treated unfairly, constantly complain, and are persistently petulant and discontented. They often have problems with authority and, if employed, have job difficulties.

Millon has subdivided the passive-aggressive (negativistic) personality disorder into four subtypes. Patients with an 8A3 code closely resemble the circuitous negativistic subtype. They retain the essential features of the passive-aggressive (negativistic) personality and have

features of the dependent personality. This subtype closely corresponds to the original meaning of the passive-aggressive personality in that these patients express their oppositional behavior indirectly and in a circuitous manner. They tend to be stubborn, "forgetful," procrastinating, neglectful, dawdling, and dependent. These behaviors are usually unconscious and these patients remain disagreeable and relatively impervious to insight and pressure.

Commentary: An elevation on Scale 8A is a good indicator of problems with authority and with criminal behaviors or potential criminal behavior. Also, clinical elevations on this scale appear in a number of profile codes involving psychiatric patients. Patients with elevations on Scale 8A warrant close clinical evaluation.

Diagnosis: personality disorder not otherwise specified (NOS), passive-aggressive (negativistic) traits

8A6B

Patients with an 8A6B code display a mixture of passive compliance and obedience at one time and oppositional and negativistic behavior at the next time. They are moody, irritable, and hostile; manifest a grumbling and pessimistic demeanor; and are erratically and explosively angry and stubborn at one moment and feel guilty and contrite at the next moment. Disillusionment seems to permeate their lives. They feel misunderstood, so they vacillate between passive dependency and stubborn contrariness, which provokes discomfort and exasperation in those around them. They expect disappointment and maintain an unstable and conflictual role in relations with others. They sulk, feel unappreciated and/or that they are being treated unfairly, constantly complain, and are persistently petulant and discontented. They often have problems with authority and, if employed, have job difficulties.

Millon has subdivided the passive-aggressive (negativistic) personality disorder into four subtypes. Patients with an 8A6B code closely resemble the abrasive negativistic subtype. They retain the essential features of the passive-aggressive (negativistic) personality and have features of the aggressive/sadistic personality. The cardinal

feature of these patients is their contentious, quarrelsome, irritable, caustic, and abrasive manner that challenges their behavior. They are fault finding in a quite derogatory manner and they seem to delight in debasing others. They are quite angry people who distance others with their negativism.

Commentary: An elevation on Scale 8A is a good indicator of problems with authority and with criminal behaviors or potential criminal behaviors. Also, clinical elevations on this scale appear in a number of profile codes involving psychiatric patients. Patients with elevations on Scale 8A warrant close clinical evaluation.

Diagnosis: personality disorder not otherwise specified (NOS), passive-aggressive (negativistic) traits

8AC

Patients with an 8AC code display a mixture of passive compliance and obedience at one time and oppositional and negativistic behavior the next time. They are moody, irritable, and hostile; manifest a grumbling and pessimistic demeanor; and are erratically and explosively angry and stubborn at one moment and feel guilty and contrite at the next moment. Disillusionment seems to permeate their lives. They feel misunderstood, so they vacillate between passive dependency and stubborn contrariness, which provokes discomfort and exasperation in those around them. They expect disappointment and maintain an unstable and conflictual role in relations with others. They sulk, feel unappreciated and/or that they are being treated unfairly, constantly complain, and are persistently petulant and discontented. They often have problems with authority and, if employed, have job difficulties.

Millon has subdivided the passive-aggressive (negativistic) personality disorder into four subtypes. Patient with an 8AC code closely resemble the vacillating negativistic subtype. They retain the essential features of the passive-aggressive (negativistic) personality and have features of the borderline personality, particularly its erratic emotionality. The cardinal feature of these patients is the rapid fluctuation of their moods and behaviors. They can be aggressive and argumentative

at one moment and submissive and dependent at the next; they can appear to be self-assured and decisive yet suddenly bewildered and helpless. These behaviors are quite public and keep significant others on edge.

Commentary: An elevation on Scale 8A is a good indicator of problems with authority and with criminal behaviors or potential criminal behavior. Also, clinical elevations on this scale appear in a number of profile codes involving psychiatric patients. Patients with elevations on Scale 8A warrant close clinical evaluation.

Diagnosis: personality disorder not otherwise specified (NOS), passive-aggressive (negativistic) traits

8B2B

Patients with an 8B2B code relate in a self-sacrificing, martyrlike manner, allowing others to take advantage of them. They seem to search for relationships in which they can lean on others for security and affection. Typically, they act in an unassuming manner, denigrating themselves into believing they deserve their fate. Thus, this pattern is repeated in most relationships, making them prone to being abused. The pattern is conceptually similar to the analytic concept of masochism.

Millon has subdivided the self-defeating personality disorder into four subtypes. Patients with an 8B2B code closely resemble the oppressed masochist subtype. They retain the essential features of the self-defeating personality and have features of the depressive personality. The cardinal feature of these patients is their use of physical and psychological symptoms to elicit sympathy and to induce guilt. These patients tend to feel quite miserable, but they use these circumstances to gain love, perpetuate dependence, and avoid adult responsibilities. They displace anger and resentment toward significant others onto their physical and psychological functioning. Because these patients act helpless, others reduce their demands on them.

Diagnosis: personality disorder not otherwise specified (NOS), self-defeating (masochistic) traits

8B3

Patients with an 8B3 code relate in a self-sacrificing, martyrlike manner, allowing others to take advantage of them. They seem to search for relationships in which they can lean on others for security and affection. Typically, they act in an unassuming manner, denigrating themselves into believing they deserve their fate. Thus, this pattern is repeated in most relationships, making them prone to being abused. The pattern is conceptually similar to the analytic concept of masochism.

Millon has subdivided the self-defeating personality disorder into four subtypes. Patients with an 8B3 code closely resemble the self-undoing masochist subtype. They retain the essential features of the self-defeating personality and have features of the dependent personality. The cardinal feature of these patients is their unconsciously acting in ways that draw victimization, humiliation, disgrace, punishment, and abuse. They seem to undo any successes and provoke others into demeaning them. This pattern is quite similar to the analytic concept of the masochistic personality.

Diagnosis: personality disorder not otherwise specified (NOS), self-defeating (masochistic) traits

8B4

Patients with an 8B4 code relate in a self-sacrificing, martyrlike manner, allowing others to take advantage of them. They seem to search for relationships in which they can lean on others for security and affection. Typically, they act in an unassuming manner, denigrating themselves into believing they deserve their fate. Thus, this pattern is repeated in most relationships, making them prone to being abused. The pattern is conceptually similar to the analytic concept of masochism.

Millon has subdivided the self-defeating personality disorder into four subtypes. Patients with an 8B4 code closely resemble the virtuous masochist subtype. They retain the essential features of the self-defeating personality and have features of the histrionic personality. The cardinal feature of these patients is acting in an unselfish, self-sacrificing manner. Their sometimes saintly demeanor brings with it their expectation of gratitude and attention. However, unconsciously, they have low self-esteem and feel that the love and attention they receive have been attained through manipulation rather than through legitimate means.

Diagnosis: personality disorder not otherwise specified (NOS), self-defeating (masochistic) traits

8B8A

Patients with an 8B8A code relate in a self-sacrificing, martyrlike manner, allowing others to take advantage of them. They seem to search for relationships in which they can lean on others for security and affection. Typically, they act in an unassuming manner, denigrating themselves into believing they deserve their fate. Thus, this pattern is repeated in most relationships, making them prone to being abused. It is conceptually similar to the analytic concept of masochism.

Millon has subdivided the self-defeating personality disorder into four subtypes. Patients with an 8B8A code closely resemble the possessive masochist subtype. They retain the essential features of the self-defeating personality and have features of the passive-aggressive (negativistic) personality. The cardinal feature of these patients is a controlling, dominating, and jealous overprotectiveness that intrudes into the lives of others. They make themselves feel indispensable by being extremely self-sacrificing. Millon has described their tendency to control others in terms of "obligatory dependence." Because these patients seem to give their all to others, they feel indispensable, but others see them as too possessive and too meddling.

Diagnosis: personality disorder not otherwise spcecified (NOS), self-defeating (masochistic) traits

S1, S12B, or S13

The profile pattern of patients with an S1, S12B, or S13 code represents a more severe dysfunctional variant of the schizoid or the avoidant personality disorder. Millon has subdivided this disorder into two types. The active variant is characteristically anxious, wary, and

apprehensive, whereas the passive type is characteristically emotionally bland.

These patients have behavioral peculiarities and eccentricities and seem detached from the world around them, appearing strange and different. They tend to lean meaningless lives, drifting aimlessly from one activity to the next, remaining on the periphery of society. They are emotionally bland and tend to have flat affect, or perhaps they display an anxious wariness. They are socially detached and isolated and show a pervasive discomfort with others. They have few, if any, personal attachments and rarely develop any intimate relationships. Their thinking is irrelevant, tangential, disorganized, or autistic, and they suspiciously mistrust others. Cognitive confusion and perceptual distortions are the rule. They are self-absorbed and ruminative with feelings of derealization. They are prone to decompensate into schizophrenia if sufficiently stressed. If BR > 84, then, because of the severity of the disorder, a clinical evaluation is needed to determine if the patient is able to function on a daily basis.

Millon has further divided the schizotypal personality disorder into two subtypes. Patients with an S1, S12B, or S13 code closely resemble the insipid schizotype. They retain the essential features of the schizotypal personality and have features of the schizoid, depressive, or dependent personality styles. The cardinal features of these patients are their deficit in affective expression and their sense of depersonalization. They seem insensitive to feelings and indifferent to interpersonal stimulation. They appear bland, sluggish, and unmotivated, with vague, tangential, and confused thinking. They feel almost unreal. They cope poorly with stimulation, demands, and responsibilities and are at risk for psychotic disorders.

Diagnosis: schizotypal personality disorder

S2A or S8A

The profile pattern of patients with an S2A or S8A code represents a more severe dysfunctional variant of the schizoid or the avoidant personality disorder. Millon has subdivided this disorder into two types. The active variant is characteristically anxious, wary, and

apprehensive, whereas the passive type is characteristically emotionally bland.

These patients have behavioral peculiarities and eccentricities and seem detached from the world around them, appearing strange and different. They tend to lean meaningless lives, drifting aimlessly from one activity to the next and remaining on the periphery of society. They are emotionally bland and tend to have flat affect, or perhaps they display an anxious wariness. They are socially detached and isolated and show a pervasive discomfort with others. They have few, if any, personal attachments and rarely develop any intimate relationships. Their thinking is irrelevant, tangential, disorganized or autistic, and they suspiciously mistrust others. Cognitive confusion and perceptual distortions are the rule. They are self-absorbed and ruminative and have feelings of derealization. They are prone to decompensate into schizophrenia if sufficiently stressed. If BR > 84, then, because of the severity of the disorder, a clinical evaluation is needed to determine if the patient is able to function on a daily basis.

Millon has further divided the schizotypal personality disorder into two subtypes. Patients with an S2A or S8A code closely resemble the timorous schizotype. They retain the essential features of the schizotypal personality and have features of the avoidant or passive-aggressive (negativistic) personality styles. The cardinal feature of these patients is their sense of depersonalization and derealization. They are apprehensive, suspicious, guarded, and socially introverted. They feel quite alienated, lack a sense of self worth, and suppress their feelings. They may appear eccentric and peculiar, and they engage in bizarre behavior. Hallucinations may be present.

Diagnosis: schizotypal personality disorder

C2A, C2B, or C3

Patients with a C2A, C2B, or C3 code have conflicting and ambivalent feelings, intensely resenting those on whom they depend yet being preoccupied with maintaining their emotional support. They show persistent attachment disorders with patterns of intense but unstable relationships. They tend to experience intense but labile

emotions and frequent mood swings with recurring periods of depression, anxiety, or anger followed by dejection and apathy. They often present with intense affect and with a history of impulsive behaviors. Manifestations of cheerfulness are often temporary coverups that mask deep fears of insecurity and fears of abandonment. They have strong dependency needs and are preoccupied with seeking attention and emotional support and need considerable reassurance. These people are particularly vulnerable to separation from those who emotionally support them. Feelings of idealization are usually followed by feelings of devaluation, and there is considerable interpersonal ambivalence. They lack a clear sense of their own identity, and this uncertainty leads them to constantly seek approval, attention, and reaffirmation. Splitting and projective identification are their major defenses. They often have a punishing conscience and are prone to acts of self-mutilation and suicidal gestures. They are also prone to brief psychotic episodes and substance abuse.

Millon has subdivided the borderline personality disorder into four subtypes. Patients with a C2A, C2B, or C3 code closely resemble the discouraged borderline subtype. They retain the essential features of the borderline personality and have features of the avoidant, depressive, or dependent personality styles. The cardinal features of these patients are their excessive compliance, acquiescence, and submissiveness to a person on whom they depend for security. However, they feel quite insecure and periodically erupt in angry outbursts of resentment. They tend to be chronically depressed, feel helpless and hopeless, and may be at risk for suicidal gestures, self-mutilation, or other acts of self-punishment.

Diagnosis: borderline personality disorder

C2B or C8B

Patients with a C2B or C8B code have conflicting and ambivalent feelings, intensely resenting those on whom they depend yet being preoccupied with maintaining their emotional support. They show persistent attachment disorders with patterns of intense but unstable relationships. They tend to experience intense but labile emotions and

frequent mood swings with recurring periods of depression, anxiety, or anger followed by dejection and apathy. They often present with intense affect and with a history of impulsive behaviors. Manifestations of cheerfulness are often temporary coverups that mask deep fears of insecurity and fears of abandonment. They have strong dependency needs and are preoccupied with seeking attention and emotional support and need considerable reassurance. These people are particularly vulnerable to separation from those who emotionally support them. Feelings of idealization are usually followed by feelings of devaluation, and there is considerable interpersonal ambivalence. They lack a clear sense of their own identity, and this uncertainty leads them to constantly seek approval, attention, and reaffirmation. Splitting and projective identification are their major defenses. They often have a punishing conscience and are prone to acts of self-mutilation and suicidal gestures. They are also prone to brief psychotic episodes and substance abuse.

Millon has subdivided the borderline personality disorder into four subtypes. Patients with a C2B or C8B code closely resemble the self-destructive borderline subtype. They retain the essential features of the borderline personality and have features of the depressive or self-defeating personalities. The cardinal feature of these patients is the conflict between their fear of autonomy and their need to be dependent and submissive to maintain a sense of security. They require constant emotional support and become dejected and depressed when they perceive this to be lacking. Then they become contrary and overemotional. At others times, they may appear self-sacrificing, suppressing their resentment and hostility. However, this form of behavior is self-defeating in the long run and prevents the acquisition of independent behaviors.

Diagnosis: borderline personality disorder

C4 or C6A

Patients with a C4 or C6A code have conflicting and ambivalent feelings, intensely resenting those on whom they depend yet being preoccupied with maintaining their emotional support. They show persis-

tent attachment disorders with patterns of intense but unstable relationships. They tend to experience intense but labile emotions and frequent mood swings with recurring periods of depression, anxiety, or anger followed by dejection and apathy. They often present with intense affect and with a history of impulsive behaviors. Manifestations of cheerfulness are often temporary coverups that mask deep fears of insecurity and fears of abandonment. They have strong dependency needs, are preoccupied with seeking attention and emotional support, and need considerable reassurance. These people are particularly vulnerable to separation from those who emotionally support them. Feelings of idealization are usually followed by feelings of devaluation, and there is considerable interpersonal ambivalence. They lack a clear sense of their own identity, and this uncertainty leads them to constantly seek approval, attention, and reaffirmation. Splitting and projective identification are their major defenses. They often have a punishing conscience and are prone to acts of self-mutilation and suicidal gestures. They are also prone to brief psychotic episodes and substance abuse.

Millon has subdivided the borderline personality disorder into four subtypes. Patients with a C4 or C6A code closely resemble the impulsive borderline subtype. They retain the essential features of the borderline personality and have features of the histrionic and antisocial personality styles. The cardinal features of these patients are their superficiality, seductiveness, and constant need for attention combined with irresponsibility and flighty and impulsive behaviors. They tend to be restless, live for the moment, and resent the confinements of social rules and regulations. Fear of abandonment may underlie much of their behavior.

Diagnosis: borderline personality disorder

C8A

Patients with a C8A code have conflicting and ambivalent feelings, intensely resenting those on whom they depend yet being preoccupied with maintaining their emotional support. They show persistent attachment disorders with patterns of intense but unstable relationships. They tend to experience intense but labile emotions and frequent mood swings with recurring periods of depression, anxiety, or anger followed by dejection and apathy. They often present with intense affect and with a history of impulsive behaviors. Manifestations of cheerfulness are often temporary coverups that mask deep fears of insecurity and fears of abandonment. They have strong dependency needs, are preoccupied with seeking attention and emotional support, and need considerable reassurance. These people are particularly vulnerable to separation from those who emotionally support them. Feelings of idealization are usually followed by feelings of devaluation, and there is considerable interpersonal ambivalence. They lack a clear sense of their own identity, and this uncertainty leads them to constantly seek approval, attention, and reaffirmation. Splitting is their main defense mechanism.

Millon has subdivided the borderline personality disorder into four subtypes. Patients with a C8A code closely resemble the petulant borderline subtype. They retain the essential features of the borderline personality and have features of the passive-aggressive (negativistic) personality, particularly traits of anger, resentment, restlessness, and complaining tendencies, along with unpredictability. They fear abandonment and isolation but also resent their dependence on others, so they vacillate between being apologetic and overtly irritable. Their chronic negativism may result in self-punishing acts or angry tirades that are out of control. These behaviors may be the result of internal conflicts with issues of separation and individuation.

Diagnosis: borderline personality disorder

P2A

Millon believes that patients with a P2A code are conflicted between issues of control and of affiliation. They vigilantly mistrust others and have an abrasive, hostile, irritable, touchy, and irascible demeanor; they readily attack and humiliate anyone whom they perceive as trying to control them. They may become belligerent, with such behavior stemming from distorted cognitions or actual delusions. They tend to

magnify interpersonal slights, are prone to distort events to support their own suspicions, and strongly resist external influence. They are fiercely independent and tend to be provocative in interpersonal relationships, precipitating fear and exasperation in those around them. Their thinking is rigid and they often become argumentative. Projection is their main defense. They are particularly sensitive to perceived threats to their own sense of self-determination. Delusions of grandeur or persecution or ideas of reference may be present in the more extreme form of the disorder.

Millon has subdivided the paranoid personality disorder into five subtypes. Patients with a P2A code closely resemble the insular paranoid subtype. They retain the essential features of the paranoid personality and have features of the avoidant personality. These patients are fearful of being controlled, so they exhibit an avoidant personality style, characterized by a withdrawn, seclusive, and secretive (lack of) interpersonal style, to prevent others from controlling them. They are quite frightened and protectively withdrawn, fearing that people are trying to poison them or do them harm in other ways. They eventually withdraw into a world of unreality.

Diagnosis: paranoid personality disorder

P5

Millon believes that patients with a P5 code are conflicted between issues of control and of affiliation. They vigilantly mistrust others and have an abrasive, hostile, irritable, touchy, and irascible demeanor; they readily attack and humiliate anyone whom they perceive as trying to control them. They may become belligerent, such behavior stemming from distorted cognitions or actual delusions. They tend to magnify interpersonal slights, are prone to distort events to support their own suspicions, and strongly resist external influence. They are fiercely independent and tend to be provocative in interpersonal relationships, precipitating fear and exasperation in those around them. Their thinking is rigid and they often become argumentative. Projection is their main defense. They are particularly sensitive to perceived threats to their own sense of self-determination. Delusions of grandeur

or persecution or ideas of reference may be present in the more extreme form of the disorder.

Millon has subdivided the paranoid personality disorder into five subtypes. Patients with a P5 code closely resemble the fanatic paranoid subtype. They retain the essential features of the paranoid personality and have features of the narcissistic personality. The cardinal features of these patients are grandiose ideas and expansive, delusional plans. These patients have suffered a perceived blow to their self-esteem and counteract this devastating narcissistic wound by developing grandiose delusions. Typically, they assert they are on some grand mission, often of a supernatural or extravagant nature. Obvious contradictions and objective facts hold no sway in convincing these patients of their erroneous beliefs.

Diagnosis: paranoid personality disorder

P6B

Millon believes that patients with a P6B code are conflicted between issues of control and of affiliation. They vigilantly mistrust others and have an abrasive, hostile, irritable, touchy, and irascible demeanor; they readily attack and humiliate anyone whom they perceive as trying to control them. They may become belligerent, with such behavior stemming from distorted cognitions or actual delusions. They tend to magnify interpersonal slights, are prone to distort events to support their own suspicions, and strongly resist external influence. They are fiercely independent and tend to be provocative in interpersonal relationships, precipitating fear and exasperation in those around them. Their thinking is rigid and they often become argumentative. Projection is their main defense. They are particularly sensitive to perceived threats to their own sense of self-determination. Delusions of grandeur or persecution or ideas of reference may be present in the more extreme form of the disorder.

Millon has subdivided the paranoid personality disorder into five subtypes. Patients with a P6B code closely resemble the malignant paranoid subtype. They retain the essential features of the paranoid personality and have features of the aggressive/sadistic personality

style. The cardinal feature of these patients is their persecutory and grandiose delusions. They tend to be belligerent, intimidating, argumentative, antagonistic, abrasive, tyrannical, hostile, and brutal. They imagine that people are constantly plotting against them and are easily provoked into aggressive behaviors, though some may limit their hostility to fantasy only.

Diagnosis: paranoid personality disorder

P7

Millon believes that patients with a P7 code are conflicted between issues of control and of affiliation. They vigilantly mistrust others and have an abrasive, hostile, irritable, touchy, and irascible demeanor; they readily attack and humiliate anyone whom they perceive as trying to control them. They may become belligerent, with such behavior stemming from distorted cognitions or actual delusions. They tend to magnify interpersonal slights, are prone to distort events to support their own suspicions, and strongly resist external influence. They are fiercely independent and tend to be provocative in interpersonal relationships, precipitating fear and exasperation in those around them. Their thinking is rigid and they often become argumentative. Projection is their main defense. They are particularly sensitive to perceived threats to their own sense of self-determination. Delusions of grandeur or persecution or ideas of reference may be present in the more extreme form of the disorder.

Millon has subdivided the paranoid personality disorder into five subtypes. Patients with a P7 code closely resemble the obdurate paranoid subtype. They retain the essential features of the paranoid personality and have features of the compulsive personality style. The cardinal feature of these patients is a well-entrenched and encapsulated delusional style. These patients may appear relatively normal until their delusional system is attacked. Then they become self-righteous and overly legalistic, use excessive intellectualization, and become increasingly hostile and irrational.

Diagnosis: paranoid personality disorder

P8A

Millon believes that patients with a P8A code are conflicted between issues of control and affiliation. They vigilantly mistrust others and have an abrasive, hostile, irritable, touchy, and irascible demeanor; they readily attack and humiliate anyone whom they perceive as trying to control them. They may become belligerent, with such behavior stemming from distorted cognitions or actual delusions. They tend to magnify interpersonal slights, are prone to distort events to support their own suspicions, and strongly resist external influence. They are fiercely independent and tend to be provocative in interpersonal relationships, precipitating fear and exasperation in those around them. Their thinking is rigid and they often become argumentative. Projection is their main defense. They are particularly sensitive to perceived threats to their own sense of self-determination. Delusions of grandeur or persecution or ideas of reference may be present in the more extreme form of the disorder.

Millon has subdivided the paranoid personality disorder into five subtypes. Patients with a P8A code closely resemble the querulous paranoid subtype. They retain the essential features of the paranoid personality and have features of the passive-aggressive (negativistic) personality style. The cardinal features of these patients are delusions and extreme hostility. These patients may be described as argumentative, petulant, jealous, fault finding, disdainful, stubborn, pessimistic, resentful, aggressive, and negativistic. Millon has reported that this subtype is prone to experience erotic delusions and to commit molestations.

Diagnosis: paranoid personality disorder

CLINICAL SYNDROMES

Anxiety (Scale A)

Patients with scores of BR > 84 on Scale A have reported many symptoms associated with anxiety. High scores on this scale are often seen in patients who are restless, anxious, apprehensive, edgy, and jittery. These patients tend to have a variety of somatic complaints associated

with physiological overarousal, including insomnia, headaches, nausea, cold sweats, undue perspiration, clammy hands, and palpitations. The intensity of these symptoms appears to be experienced by the patient as quite severe and possibly disabling.

Diagnosis: generalized anxiety disorder, unless specific phobias or trauma explain the symptom picture

Somatoform Disorder (Scale H)

Patients with scores of BR > 84 on Scale H appear to be persistently preoccupied with perceptions of poor health and report symptoms that may not correspond to clearly defined organic disorders. Similar patients often express their psychological problems by developing symptoms that defy clear-cut medical diagnoses. Others may have a legitimate physical condition but do not cope well with it. In either case, these patients are often whining, demanding, and complaining and tend to deny psychological or emotional factors affecting the development or exacerbation of their physical disorder.

Diagnosis: rule out somatoform disorder and psychological factors affecting physical condition

Bipolar Disorder, Manic (Scale N)

Patients who score at the level of BR > 84 on Scale N often report symptoms primarily consisting of labile emotions, including both mania and depression. These symptoms may be the result of substance abuse or of a primary disorder that is being self-medicated by substance abuse (see Scales B, page 187, and T, page 188), or the two conditions may coexist independent of one another. A more thorough clinical evaluation for affective disorders and/or substance abuse is recommended.

Diagnosis: bipolar disorder, manic

Dysthymia (Scale D)

Patients with a score of BR > 84 on Scale D have many problems and symptoms associated with depression. These may 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 meet their day-to-day responsibilities but continue to experience chronic dysphoria.

Diagnosis: dysthymic disorder

Alcohol Dependence (Scale B)

Patients with a score of BR > 84 on Scale B have reported symptoms and traits commonly associated with alcohol abuse, alcohol dependence, or both. It is also possible that these patients have endorsed personality traits often seen in those who subsequently develop problematic drinking or that these patients have had problems with alcohol and are now in recovery. A more thorough evaluation should be conducted to determine the presence of any specific problems (e.g., medical, social, legal, psychological, psychiatric, vocational, spiritual) that may be associated with this condition. Scores at this level almost always reflect a diagnosis associated with alcohol.

Diagnosis: alcohol abuse dependence

Drug Dependence (Scale T)

Patients with scores of BR > 84 on Scale T have reported symptoms and traits commonly associated with drug abuse, drug dependence, or both. It is also possible that these patients have endorsed personality traits often seen in those who subsequently develop problems associated with drug abuse or that these patients have had problems with drugs and are now in recovery. A more thorough evaluation should be conducted to determine the presence of any specific problems (e.g., medical, social, legal, psychological, psychiatric, vocational, spiritual) that may be associated with this condition. Scores at this level almost always reflect a diagnosis associated with drug abuse.

Diagnosis: drug abuse or drug dependence

Posttraumatic Stress Disorder (Scale T)

Patients with scores of BR > 84 on Scale T have reported symptoms often associated with posttraumatic stress. These symptoms might include distressing and intrusive thoughts; flashbacks; startle responses; emotional numbing; problems in anger management; difficulties with sleep or concentration; and psychological distress on exposure to people, places, or events that symbolize or resemble some aspect of the traumatic event. A clinical evaluation is suggested to determine which symptoms are present and the degree of functional impairment. If there is no trauma in the patient's history, then scores at this level could suggest emotional turmoil of a nontraumatic nature.

Diagnosis: posttraumatic stress disorder

Thought Disorder (Scale SS)

Patients with scores of BR > 84 on Scale SS have reported a number of symptoms associated with a possible thought disorder, ranging from confused, fragmented, and bizarre thinking to scattered hallucinations and unsystematized delusions. A more thorough clinical evaluation is highly recommended.

Diagnoses: rule out brief reactive psychosis, schizophreniform disorder, and schizophrenia

Major Depression (Scale CC)

Patients with scores of BR > 84 on Scale CC have reported many problems and symptoms associated with depression, including feelings of inadequacy and worthlessness, a loss of energy, diminished desire for sex or engagement in formerly pleasurable activities, loss of appetite, reduced ability to think or concentrate, possible suicidal ideation, and a chronically depressed mood. These patients usually are unable to carry on their daily activities without treatment intervention. A more thorough clinical review is recommended.

Diagnosis: major depression

Delusional Disorder (Scale PP)

Patients with high scores on Scale PP have reported many symptoms usually associated with paranoia. Their mood may be hostile and they may be hypervigilant to perceived threats. Ideas of reference, thought control, or thought influence may be present. A more thorough clinical evaluation is recommended to determine which specific symptoms are present and what kind of clinical intervention is necessary.

Diagnosis: delusional disorder

SCALE INTERACTIONS OR COMBINATIONS

Elevations on some scales might change the interpretation of other scales. Below are some of the more common scale interactions and associated interpretations. Refer to the original scale to see what has been added changed.

Scale 3 with Another Scale

- Scale A, BR > 74: Because this patient is reporting many anxiety symptoms, it is recommended that the clinician determine if support systems have become unreliable, which may the source of this anxiety.
- Scale D, BR > 74: Because this patent is reporting many symptoms associated with depression, it is recommended that the clinician determine exactly which support systems have become unreliable, which may the source of this dysphoria.
- Scale A and D, BR > 74: Because this patient is reporting many symptoms associated with both anxiety and depression, it is recommended that the clinician determine if support systems have become unreliable, which may be the source of this psychological distress.
- Scale B or T, BR > 74: Because this patient is reporting many symptoms and behaviors associated with substance abuse, it

is recommended that the clinician determine whether the patient is a substance abuser with a dependent personality or has recently turned to abusing substances to cope with the anxiety associated with the loss of security in relationships.

- Scale D or CC, BR > 84: Because this patient may have a clinical depression, the personality profile described here may be a manifestation of depression and not the patient's basic personality style. If this is true, then these symptoms and behaviors should abate when the depression has been successfully treated and the patient may not look so dependent. However, Millon has argued that the clinical symptoms are an extension of personality style, so that although the intensity of expression may be reduced somewhat, the essential features of a dependent personality style may remain.

Scale N with Another Scale

- Scale B or T, BR > 74: Patients who score at this level of Scale N often have symptoms of labile emotions and frequent mood swings, including behaviors characterized by mania. These symptoms may be the result of substance abuse or of a primary manic disorder that is being self-medicated by substance abuse, or the two conditions may coexist independently of one another. A more thorough clinical evaluation is recommended.
- Scale PP, BR > 84: This patient is reporting symptoms of labile emotions, including both mania and depression, and of hallucinations, delusions, or both. A more thorough clinical evaluation is recommended.
- Scale PP, BR > 84; Scale B or T, BR > 74; and/or Scale D or CC > 74: This patient is reporting symptoms of labile emotions, including both mania and depression, and of hallucinations, delusions, or both. These symptoms may be due to a primary affective disorder with psychotic features, to a primary delusional disorder with affective features, to a substance abuse disorder (especially hallucinogenic use of PCP), or to one or more of these disorders that co-exist independently of one another. A more thorough clinical evaluation is recommended.

Scale D with Scale B or T, BR > 74

This depression may be secondary to substance abuse, particularly alcoholism or alcohol abuse. A more thorough clinical evaluation is recommended to determine if there are vegetative signs of depression and to determine which disorder, depression, or substance abuse is primary.

Scale SS with Scale B or T, BR > 74

Toxic or drug-induced psychosis should be ruled out as a cause of this thought disorder.

Scale PP with Scale B or T, BR > 74

Given the apparent substance abuse of patients with scores of BR > 74 on Scales PP and B or T, a drug-induced paranoia may 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, B, and T. Thus, it may be the case that these patients' primary diagnosis is substance abuse and the traits and behaviors, such as hypervigilance, defensive scanning of the environment, and a feeling that people are out to get them, are really associated with the drug abuser lifestyle rather than with clinical paranoia. A clinical evaluation is necessary to determine which diagnosis is the case. A delusional paranoid disorder, a paranoid disorder, or a drug-induced paranoid condition, such as toxic psychosis, should be considered.

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CHAPTER 3

California Psychological Inventory–Revised Interpretive Manual

General Overview

THE CALIFORNIA PSYCHOLOGICAL INVENTORY (CPI) was initially published in 1957 and last revised in 1996 as the CPI-R. Consisting of 434 items requiring a fifth-grade reading ability, the test was restandardized using 3,000 men and 3,000 women as test subjects. Although the test was designed for use with people aged 13 and above, it is really an adult personality test, though some scales have a substantial research base with high school students. A total of 158 items also appear in the Minnesota Multiphasic Personality Inventory–2 (MMPI-2). It has cross-cultural applications and has been translated into 29 foreign languages. Recent factor analysis studies reported five general factors labeled Ascendance (I), Dependability (II), Communality/Conventionality (III), Originality (IV), and Femininity/Masculinity (V).

Philosophical Basis of the CPI-R

Harrison Gough, the test's developer, decided to create a personality inventory that would be designed for use with nonclinical populations and would use concepts that are already part of everyday language to