

Millon Clinical Multiaxial Inventory II/III

Narrative Report

by

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and

PAR Staff

Client Information

Client Name: Sample

Client ID:

Date of Evaluation: 03/13/2006

Age: 43

Gender: Male

Education: 12

Marital Status: Single

Setting: Inpatient

The MCMI (as revised) was normed on individuals being evaluated or treated in mental health settings. Thus, the test should only be used with individuals who are in similar clinical settings for problems that are defined as psychological/psychiatric. Administering this test to people without clinical symptoms is inappropriate and will result in inaccurate descriptions of their functioning. Because this test is focused on personality disorders and clinical symptoms, the report is necessarily focused on these problematic behaviors, and cannot describe a person's strengths and competencies.

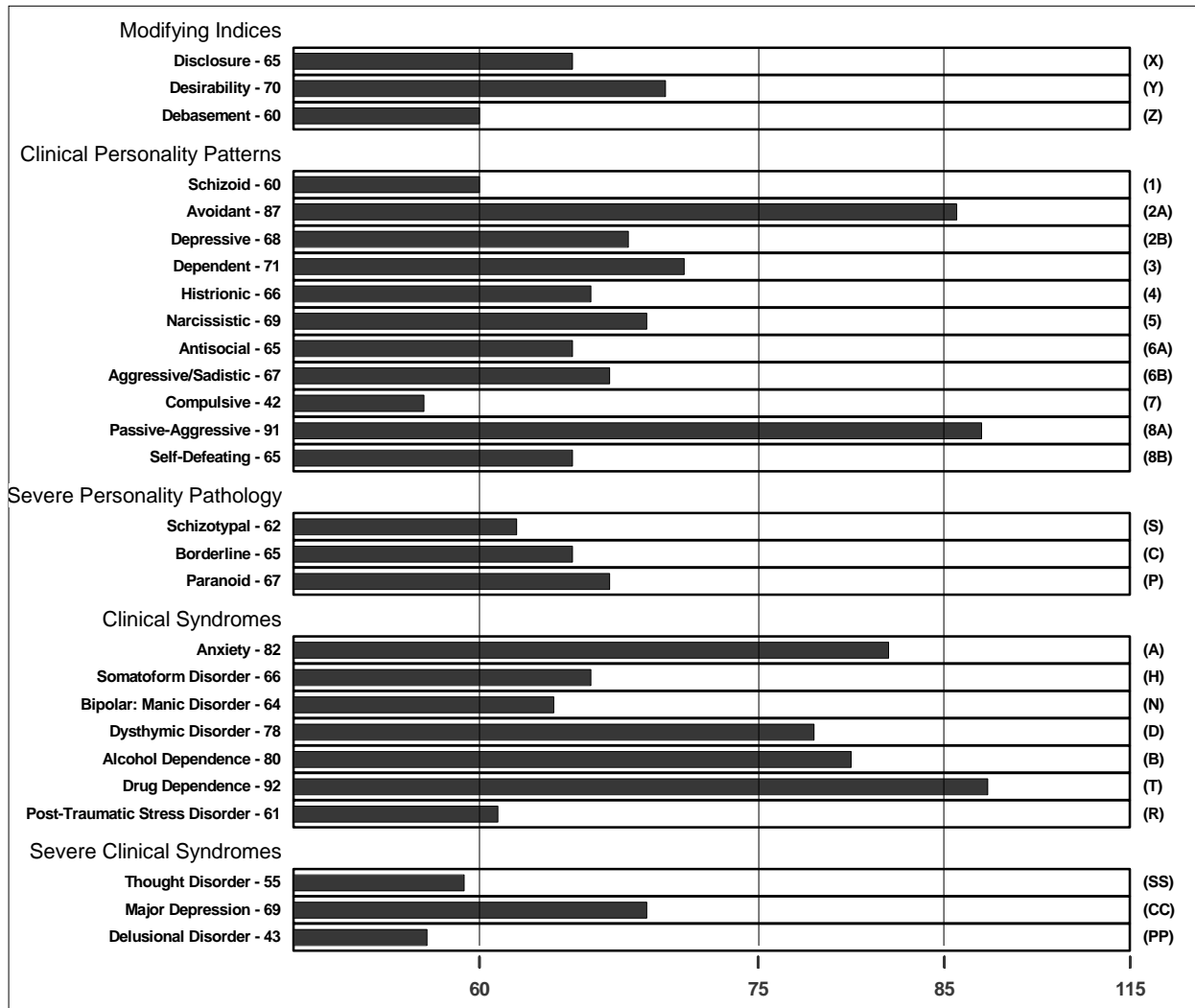
The interpretive information contained in this report should be viewed as only one source of hypotheses about the individual being evaluated. No decisions should be based solely on the information contained in this report. This material should be integrated with all other sources of information in reaching professional decisions about this individual. This report is confidential and intended for use by qualified professionals only. It should not be released to the individual being evaluated.

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Version: 2.00.010

MCMII – II/III Profile



Modifier Indices Configurations

This patient's response style in taking this test appeared to be open and honest and no response distortions appear evident. The results of this test are likely to be valid.

Disclosure Level (X)

This patient responded to the MCMI items by using an appropriate amount of self-disclosure, and no defensive test-taking attitudes appear evident. This suggests that the patient was cooperative with the testing process.

Desirability Gauge (Y)

This patient showed no tendency to respond to the MCMI items in a socially desirable manner. This suggests the patient may have cooperated with the testing process.

Debasement (Z)

This patient is reporting an appropriate level of behavioral, emotional, or interpersonal problems and shows no tendency to underreport or exaggerate those difficulties.

Personality Style

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These patients display a mixture of passive compliance and obedience at one time and then oppositional and negativistic behavior the next time. They are moody, irritable, and hostile; they manifest a grumbling and pessimistic demeanor; and they 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 that 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.

This patient presents as socially awkward, withdrawn, introverted, and self-conscious. Because people such as this patient are hypersensitive to rejection and fear 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 also may be present but all stemming from the same issue--a desire for social acceptance and a fear of rejection. Most often, they maintain a social distance in order 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 but also in loneliness, isolation, and continued shyness and timidity. These people are at risk for social phobias.

Commentary: Elevations in Scale 8A are a good indicator of problems with authority and with criminal behaviors or potential for 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.

Possible Diagnosis: Personality Disorder Not Otherwise Specified, Passive-Aggressive (negativistic) and Avoidant Personality Disorder.

Additional Personality Disorder Scales

This section provides narrative statements covering scales that were not considered primary in the profile code. However, this section may contain important information on additional personality traits. In some cases, information in these scales may appear inconsistent or contradictory to statements made in the main report. The clinician needs to determine which statements are applicable to the individual patient.

Schizoid (1)

This patient is likely to be viewed as a wallflower. Interpersonal relationships are generally absent but, if present, they do not seem central to the patient's personal happiness. Traits that describe scores at this level include introverted, quiet, dependent, self-sacrificing, passive, timid, and uncommunicative. Such people appear emotionally bland and even indifferent to events in their lives. These patients may lack affective expression with deficiencies in social communication. They prefer a simple life and defer to someone else in the management of their day-to-day life. They have little drive or ambition and prefer isolated activities to group involvement. If this patient is in a committed relationship, the spouse may complain about this person's lack of affection and, perhaps, reduced interest in sex.

Depressive (2B)

This patient has reported some traits associated with a depressive personality style but not in sufficient quantity to be diagnostically significant.

Dependent (3)

This patient has mild dependency needs that seem to drive many aspects of behavior. Timidity, some withdrawal tendencies, passivity, and perhaps demureness may be part of the personality constellation. Personal needs are sometimes sacrificed in order for the patient to please others. The patient does not take a dominant role in relationships and may take on too many tasks in order to please significant others. The patient is unlikely to erupt in emotional outbursts. These traits are not at sufficient intensity to warrant a personality disorder diagnosis and are more stylistic in nature than pathological.

Histrionic (4)

This patient has high needs for attention, recognition, and praise, and has a gregarious and extroverted personality style. Rather than acting seductively, dramatically, or in a manipulative manner, which characterizes patients who score at higher levels on this scale, the patient uses a natural charm and wit to have these needs met. When the patient becomes overly demanding, it usually is with close family relationships or within a work setting. Rarely is this style a cause of interpersonal disruption.

Narcissistic (5)

This patient shows some evidence of narcissistic-like traits. It is not possible to determine exactly which ones are manifest, and a clinical interview would be needed for more exact characterization. This patient probably does have high self-esteem.

Antisocial (6A)

This patient shows some evidence of antisocial-like traits. It is not possible to determine exactly which ones are manifest, and a clinical interview would be needed for more exact characterization.

Aggressive/Sadistic (6B)

This patient shows some evidence of aggressive traits. It is not possible to determine exactly which ones are manifest, and a clinical interview would be needed for more exact characterization.

Compulsive (7)

Millon does not provide information on nor does he interpret low scale scores. However, a low score on Compulsive might suggest a lack of conformity and low impulse control.

Self-Defeating (8B)

This patient shows some evidence of self-defeating traits. It is not possible to determine exactly which ones are manifest and a clinical interview would be needed for more exact characterization.

Schizotypal (S)

This patient shows few, if any, symptoms, behaviors, or traits associated with a schizotypal personality disorder.

Borderline (C)

This patient shows some evidence of borderline traits. It is not possible to determine exactly which ones are manifest and a clinical interview would be needed for more exact characterization.

Paranoid (P)

This patient shows few, if any, symptoms, behaviors, or traits associated with a paranoid personality disorder.

Clinical Syndromes

Anxiety (A)

This patient has 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. These complaints could include insomnia, headaches, nausea, cold sweats, undue perspiration, clammy hands, and palpitations. These symptoms appear to be experienced by the patient at a moderate degree of intensity.

Somatoform Disorder (H)

This patient shows only mild tendencies toward somatization.

Bipolar: Manic Disorder (N)

This patient reports some manic-like symptoms. The cause may be related to substance abuse, or the patient may have a recently developed Bipolar Affective Disorder and is self-medicated with substance abuse. A closer clinical evaluation is suggested.

Dysthymic Disorder (D)

This patient is reporting many problems and symptoms associated with depression. These problems and symptoms 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 a chronic dysphoria. A diagnosis associated with depression is usually associated with scores at this level, with Dysthymic Disorder being the most prevalent diagnosis. However, 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.

Possible Diagnosis: Rule out Dysthymic Disorder; Rule out Alcohol Abuse or Dependence; Rule out Drug Abuse or Dependence.

Alcohol Dependence (B)

This patient has reported symptoms and traits commonly associated with alcohol abuse and/or alcohol dependence. It also is possible that the patient has endorsed personality traits often seen in patients who subsequently develop problematic drinking. It also is possible that the patient has had problems with alcohol and is in recovery. A more thorough evaluation of the patient's drinking history, pattern and problems is recommended.

Drug Dependence (T)

This patient has reported symptoms and traits commonly associated with drug abuse and/or drug dependence. It also is possible that the patient has endorsed personality traits often seen in patients who subsequently develop problems associated with drug abuse. It also is possible that

the patient has had problems with drugs and is in recovery. A more thorough clinical evaluation should be conducted to determine the presence of any specific problems that may be associated with this condition (e.g., medical, social, legal, psychological, psychiatric, vocational, spiritual). Scores at this level almost always reflect a diagnosis associated with drug abuse.

Possible Diagnosis: Drug Abuse/Dependence.

Post-Traumatic Stress Disorder (R)

This patient reports no symptoms associated with post-traumatic stress disorder.

Thought Disorder (SS)

This patient reports no abnormalities consistent with a thought disorder.

Major Depression (CC)

This patient is reporting some mild signs of depression, but not of sufficient severity to impair daily functioning.

Delusional Disorder (PP)

This patient reports no symptoms associated with a delusional disorder.

Research

The following studies have found this codetype among the populations indicated below:

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- (1) 25 Vietnam veterans with PTSD (Robert, J. A., Ryan, J. J., McEntyre, W. L., McFarland, R. S., Lips, O. J., & Rosenberg, S. J. [1985]. MCMII characteristics of *DSM-III*: Posttraumatic stress disorder in Vietnam veterans. *Journal of Personality Assessment*, 49, 226-230.)
- (2) 144 depressed alcoholics (McMahon, R. C., & Davidson, R. S. [1986]. An examination of depressed vs. nondepressed alcoholics in inpatient treatment. *Journal of Clinical Psychology*, 42, 177-184.)
- (3) 189 Vietnam veterans with PTSD (Sherwood, R. J., Funari, D. J., & Piekarski, A. M. [1990]. Adapted character styles of Vietnam veterans with posttraumatic stress disorder. *Psychological Reports*, 66, 623-631.)
- (4) 100 Vietnam veterans with PTSD (Hyer, L. A., Albrecht, J. W., Boudewyns, P. A., Woods, M. G., & Brandsma, J. [1993]. Dissociative experiences of Vietnam veterans with chronic posttraumatic stress disorder. *Psychological Reports*, 73, 519-530.)
- (5) 34 angry, nonpsychotic, black, psychiatric inpatients (Greenblatt, R. L., & Davis, W. E. [1992]. Accuracy of MCMII classification of angry and psychotic Black and White patients. *Journal of Clinical Psychology*, 48, 59-63.)
- (6) Cluster analysis Type I Vietnam veterans with PTSD (sample size not indicated) (Hyer, L., Davis, H., Albrecht, W., Boudewyns, P. A., & Woods, G. [1994]. Cluster analysis of MCMII and MCMII-II of chronic PTSD victims. *Journal of Clinical Psychology*, 50, 502-515.) (MCMII-II)
- (7) 69 patients treated in a military mental hygiene clinic (Rudd, M. D., & Orman, D. T. [1996]. Millon Clinical Multiaxial Inventory profiles and maladjustment in the military: Preliminary findings. *Military Medicine*, 161, 349-351.)
- (8) 182 male and 73 female substance abusers (Nadeau, L., Landry, M., & Racine, S. [1999]. Prevalence of personality disorders among clients in treatment for addiction. *Canadian Journal of Psychiatry*, 44, 592-596.)

References

Additional interpretive material and test information is available in the following resources. The reader is encouraged to consult these sources for more specific test information.

Choca, J. P. (2003). *Interpretive guide to the Millon Clinical Multiaxial Inventory* (3rd ed.). Washington, DC: American Psychological Association.

Craig, R. J. (1993). *Psychological assessment with the Millon Clinical Multiaxial Inventory (II): An interpretive guide*. Odessa, FL: Psychological Assessment Resources.

Craig, R. J. (Ed.) (1993). *The Millon Clinical Multiaxial Inventory: A clinical research information synthesis*. Hillsdale, NJ: Erlbaum.

Craig, R. J. (Ed.). (2005). *New directions in interpreting the Millon Clinical Multiaxial Inventory-III (MCMI-III)*. New York: Wiley.

Millon, T., Davis, R., & Millon, C. (1997). *Millon Clinical Multiaxial Inventory-III (MCMI-III) manual*. Bloomington, MN: Pearson Assessments.