MCMI®-IV

MILLON® CLINICAL
MULTIAXIAL INVENTORY–IV

MCMI®-IV
Millon® Clinical Multiaxial Inventory-IV
Interpretive Report

Theodore Millon, PhD, DSc, & Seth Grossman, PsyD

Name:	Sample Adult
ID Number:	575824
Age:	43
Gender:	Unspecified
Setting:	Outpatient never hospitalized
Education:	Some college or technical school, associate degree
Race:	Other
Date Assessed:	05/31/2023
Administration Language:	English

[1.8 / RE1 / QG1]

REPORT SUMMARY

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

Interpretive Considerations

The patient is a 43-year-old individual with some college or technical school or an associate degree. They are currently being seen as an outpatient, and they report that they have recently experienced problems that involve loneliness and low self-confidence. The self-reported difficulties presented in this report, which have occured for an unspecified period of time, may take the form of a clinical syndrome disorder.

Profile Severity

On the basis of the test data, it may be assumed that the patient is experiencing a severe mental disorder; further professional observation and inpatient care may be appropriate. The text of the following interpretive report may need to be modulated upward given this probable level of severity.

Possible Diagnoses

They appear to fit the following personality disorder classifications best: Avoidant Personality Type, Unspecified Personality Disorder (Melancholic) Type, Compulsive Personality Style, and Schizotypal Personality Style.

Clinical syndromes are suggested by the patient's MCMI-IV profile in the areas of Major Depression (recurrent, severe) and Generalized Anxiety Disorder.

Therapeutic Considerations

This person evidences an intense conflict between wanting to seek belongingness and self-efficacy on one hand, and fearing dejection and personal disappointment on the other. Likely evoking derogation based on their occasional self-expression, which exposes self-discontent and negativity, they have a tendency to self-confirm their pessimism and become stuck. Therapeutic inroads need to be oriented to bringing awareness of any self-undermining behavior and fixedness. Efforts at diminishing oversensitivity should also prove fruitful in initiating an effective course of treatment.

MILLON CLINICAL MULTIAXIAL INVENTORY-IV

PROFILE SUMMARY

HIGH-POINT CODE = 2B 2A 7
BR ADJUSTMENTS = A/CC

INVALIDITY (V) = 0
INCONSISTENCY (W) = 5

VALIDITY		Score Raw	Score BR	Profile of BR Scores 0 35 75 100
Modifying Indices				Low / Average / High
Disclosure	X	27	45	
Desirability	Y	8	40	
Debasement	Z	13	68	

PERSONALITY		Score Raw	Score PR	Score BR	Profile of BR Scores 0 60 75 85 115
Clinical Personality Patterns					Style / Type / Disorder
Schizoid	1	6	41	52	
Avoidant	2A	13	75	77	
Melancholic	2B	15	80	77	
Dependent	3	6	50	60	
Histrionic	4A	7	28	37	
Turbulent	4B	2	11	12	
Narcissistic	5	0	3	0	
Antisocial	6A	0	6	0	
Sadistic	6B	0	5	0	
Compulsive	7	17	65	67	
Negativistic	8A	5	40	50	
Masochistic	8B	4	38	46	
Severe Personality Pathology					
Schizotypal	S	7	55	62	
Borderline	C	7	54	61	
Paranoid	P	1	24	15	

PSYCHOPATHOLOGY		Score Raw	Score PR	Score BR	Profile of BR Scores 0 60 75 85 115
Clinical Syndromes					Present / Prominent
Generalized Anxiety	A	7	61	80	
Somatic Symptom	H	8	62	68	
Bipolar Spectrum	N	1	8	12	
Persistent Depression	D	15	66	71	
Alcohol Use	B	2	70	68	
Drug Use	T	0	10	0	
Post-Traumatic Stress	R	5	61	64	
Severe Clinical Syndromes					
Schizophrenic Spectrum	SS	9	62	63	
Major Depression	CC	11	68	79	
Delusional	PP	2	63	62	

MILLON CLINICAL MULTIAXIAL INVENTORY-IV

FACET SCALES FOR HIGHEST ELEVATED PERSONALITY SCALES

FACET SCALES		Score Raw	PR	BR	Profile of BR Scores 0 35 75 100
Avoidant	**2A**				Interpretable
Interpersonally Aversive	2A.1	6	74	78	
Alienated Self-Image	2A.2	4	61	70	
Vexatious Content	2A.3	2	47	60	
Melancholic	**2B**				
Cognitively Fatalistic	2B.1	5	60	70	
Worthless Self-Image	2B.2	2	55	65	
Temperamentally Woeful	2B.3	4	65	70	
Compulsive	**7**				
Expressively Disciplined	7.1	6	72	70	
Cognitively Constricted	7.2	6	55	64	
Reliable Self-Image	7.3	8	72	75	

GROSSMAN FACET SCALE SCORES

		Raw	PR	BR
1	**Schizoid**			
1.1	Interpersonally Unengaged	2	38	60
1.2	Meager Content	6	76	72
1.3	Temperamentally Apathetic	3	56	64
2A	**Avoidant**			
2A.1	Interpersonally Aversive	6	74	78
2A.2	Alienated Self-Image	4	61	70
2A.3	Vexatious Content	2	47	60
2B	**Melancholic**			
2B.1	Cognitively Fatalistic	5	60	70
2B.2	Worthless Self-Image	2	55	65
2B.3	Temperamentally Woeful	4	65	70
3	**Dependent**			
3.1	Expressively Puerile	6	79	75
3.2	Interpersonally Submissive	3	70	70
3.3	Inept Self-Image	3	54	65
4A	**Histrionic**			
4A.1	Expressively Dramatic	0	12	0
4A.2	Interpersonally Attention-Seeking	5	41	60
4A.3	Temperamentally Fickle	1	8	12
4B	**Turbulent**			
4B.1	Expressively Impetuous	0	7	0
4B.2	Interpersonally High-Spirited	2	22	30
4B.3	Exalted Self-Image	3	30	45
5	**Narcissistic**			
5.1	Interpersonally Exploitive	0	10	0
5.2	Cognitively Expansive	2	20	24
5.3	Admirable Self-Image	0	18	0
6A	**Antisocial**			
6A.1	Interpersonally Irresponsible	0	7	0
6A.2	Autonomous Self-Image	1	27	30
6A.3	Acting-Out Dynamics	0	13	0
6B	**Sadistic**			
6B.1	Expressively Precipitate	0	10	0
6B.2	Interpersonally Abrasive	0	13	0
6B.3	Eruptive Architecture	1	49	60
7	**Compulsive**			
7.1	Expressively Disciplined	6	72	70
7.2	Cognitively Constricted	6	55	64
7.3	Reliable Self-Image	8	72	75
8A	**Negativistic**			
8A.1	Expressively Embittered	2	51	65
8A.2	Discontented Self-Image	3	44	60
8A.3	Temperamentally Irritable	1	36	60
8B	**Masochistic**			
8B.1	Undeserving Self-Image	2	40	60
8B.2	Inverted Architecture	0	13	0
8B.3	Temperamentally Dysphoric	8	89	80
S	**Schizotypal**			
S.1	Cognitively Circumstantial	5	71	66
S.2	Estranged Self-Image	4	62	64
S.3	Chaotic Content	1	43	60
C	**Borderline**			
C.1	Uncertain Self-Image	3	56	64
C.2	Split Architecture	1	34	30
C.3	Temperamentally Labile	3	59	64
P	**Paranoid**			
P.1	Expressively Defensive	0	9	0
P.2	Cognitively Mistrustful	0	14	0
P.3	Projection Dynamics	3	72	70

RESPONSE TENDENCIES

Scores for scales 2B (Melancholic), 8B (Masochistic), and C (Borderline) have been adjusted to compensate for the potential over reporting of symptoms based on the elevated scores from scales A (Generalized Anxiety) and CC (Major Depression). Additional score adjustments have also been made on scores for scales 2A (Avoidant) and S (Schizotypal).

PERSONALITY PATTERNS

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

The MCMI-IV profile of this person signifies a sorrowful and dejected state. It may also be hypothesized that they feel trapped in an intense conflict. On the one hand, their disappointments and downcast moods may lead them to withdraw from personal relationships; and on the other, they appear to dread being alone and isolated, stuck without support in situations where they must function autonomously. They may want to be close to others and respected by them, but they have learned to anticipate pain and disillusionment. Self-reproachful, pessimistic, and lacking self-esteem, this person expects to fail and to be humiliated. Others have either deprecated them or have disapproved of their occasional attempts at self-expression. These criticisms and restrictions on their freedom stir deep resentment and lead them to be melancholy and withdrawn. Others tend to see them not only as blue and dispirited, but also as sulky and irritable. Disillusioned with others for their lack of support or for having made unreasonable demands on them, this person often feels unwanted and rejected. To restrain their disappointment and resentment, as well as to protect themselves against further loss and isolation, they turn their anger inward and reinforce their tendency to feel disconsolate and mournful.

Their discontent with themselves and others and their irritable moodiness often evoke derogatory reactions from others, and such reactions serve to increase their withdrawal and depressive behavior. Because every avenue of gratification seems fraught with conflict, this person has come to prefer gloomy isolation and self-ministration. Disposed to anticipate disillusionment, however, they frequently withdraw from potentially supportive persons and thereby actually incur the disappointment they have learned to expect.

Unable to improve their life or to gain the respect of others, they have likely turned against themselves, expressing feelings of unworthiness and uselessness. Feeling unappreciated and demeaned by others, they rely on fantasy to provide them with the satisfaction they cannot attain otherwise.

Because this person sees themselves as possessing few of the attributes they admire in others and because this awareness intrudes painfully on their thoughts, they may assert that disappointment and discouragement are what life is all about. They may have come to believe that they deserve to be victimized and to suffer. This acceptance of their painful state may be short-lived. Feeling miserable, misunderstood, and unappreciated, they may become touchy and irritable; this reaction again sets into motion their withdrawal behavior and depressive moodiness, beginning the vicious circle anew.

GROSSMAN FACET SCALES

By examining the elevated Grossman Facet Scale scores for the Clinical Personality Patterns and Severe Personality Pathology scales, it is possible to identify a patient's most troublesome or clinically-significant

functional and structural domains (e.g., self-image, interpersonal conduct). A careful analysis of this individual's facet scale scores suggests the following characteristics are among their most prominent personality features.

Most notable are their broad-based social anxiety and fearful guardedness. These characteristics stem from a desire to be accepted by others that is countered by a deep fear of humiliation and rejection, which results in withdrawal and feelings of personal exclusion. They may be characteristically shy and apprehensive, display awkwardness and discomfort in social situations, and actively recoil from the give-and-take of interpersonal relations.

Also salient is their tendency to view themselves as efficient, disciplined, meticulous, and industrious. They see themselves as devoted to work and to meeting responsibilities. They tend to minimize the importance of recreational and leisure activities in favor of those that signify productive efforts. Fearful of being viewed as irresponsible or slack in their efforts, as one who fails to meet the expectations of others, or as someone who is error-prone, they may overvalue those aspects of their self-image that signify perfectionism.

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

CLINICAL SYNDROMES

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

Symptoms characteristic of a major depressive disorder personify the daily life of this melancholic and moody person. While they depend on others for nurturance, this person may also resent their own neediness and what they perceive as the unreliability of others. This person hesitates to display any anger or resentment they feel lest it precipitate the rebuke and rejection they dread from others. Instead, this person has a tendency to turn their hostilities inward, thus contributing intropunitively to self-deprecation, guilt, a diminished capacity for pleasure, feelings of unworthiness, and possible suicidal ideation. Filled with self-pity, feelings of emptiness and apprehension, a sensitivity to humiliation, and a pervasive pessimism, they see little to brighten their chronic depressive mood.

Consistent with their general downhearted style, this aggrieved and unhappy person also reports the symptomatology suggestive of a generalized anxiety disorder. Fraught with discontent and suffering in most areas of their life, they present with a steady stream of psychological tension that may include diffuse fears, mental distractibility, and fatigue. Other, more acute symptoms such as panic attacks and agoraphobia are also possible. Plagued by doubts, a pessimistic outlook on life, and repeatedly undermining opportunities to better their circumstances, this person seems to create stressors that promote the worries and anguish that characterize their general anxiety state.

NOTEWORTHY RESPONSES

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

Health Preoccupied
41. Item content omitted (True)
120. Item content omitted (True)

Interpersonally Alienated
4. Item content omitted (True)

Emotional Dyscontrol
80. Item content omitted (True)

Self-Destructive Potential
14. Item content omitted (True)
32. Item content omitted (True)
34. Item content omitted (True)
114. Item content omitted (True)

Childhood Abuse
47. Item content omitted (True)

Vengefully Prone
37. Item content omitted (True)
111. Item content omitted (True)

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

POSSIBLE *DSM-5*® DIAGNOSES

The following diagnostic assignments should be considered judgments of personality and clinical prototypes that correspond conceptually to formal diagnostic categories. The diagnostic criteria and items used in the MCMI-IV differ somewhat from those in the *DSM-5*, but there are sufficient parallels in the MCMI-IV items to recommend consideration of the following assignments. It should be noted that several *DSM-5* clinical syndromes are not assessed in the MCMI-IV. Definitive diagnoses must draw on biographical, observational, and interview data in addition to self-report inventories such as the MCMI-IV.

Before each disorder name, ICD-9-CM codes are provided, followed by ICD-10-CM codes in parentheses.

Clinical Syndromes
The major complaints and behaviors of the patient parallel the following clinical syndrome diagnoses, listed in order of their clinical significance and salience.

296.33 (F33.2) Major Depression (recurrent, severe)
300.02 (F41.1) Generalized Anxiety Disorder

Course: The clinical syndromes described previously tend to be relatively transient, waxing and waning in their prominence and intensity depending on the presence of environmental stress.

Personality Disorders
Deeply ingrained and pervasive patterns of maladaptive functioning underlie clinical syndromal pictures. The following personality prototypes correspond to the most probable *DSM-5* diagnoses that characterize this patient.

Personality configuration composed of the following:

Avoidant Personality Type
Unspecified Personality Disorder (Melancholic) Type
Compulsive Personality Style
and Schizotypal Personality Style

Course: The major personality features described previously reflect long-term or chronic traits that are likely to have persisted for several years prior to the present assessment.

Psychosocial and Environmental Problems

In completing the MCMI-IV, this individual identified the following problems that may be complicating or exacerbating their present emotional state. They are listed in order of importance as indicated by the patient. This information should be viewed as a guide for further investigation by the clinician.

Loneliness; Low Self-Confidence

TREATMENT GUIDE

The following guide to treatment planning is oriented toward issues and techniques of a short-term character, focusing on matters that might call for immediate attention, followed by time-limited procedures designed to reduce the likelihood of repeated relapses.

As a first step, it would appear advisable to implement methods to ameliorate this patient's current state of clinical anxiety, depressive hopelessness, or pathological personality functioning by the rapid implementation of supportive psychotherapeutic measures. With appropriate consultation, targeted psychopharmacologic medications may also be useful at this initial stage.

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

At the core of this person's change dilemma is a conflict involving how they orient themselves to social and situational life challenges ranging from simple interactions to major life decisions. Routinely expecting the worst possible outcomes, yet yearning for feelings of belongingness and worldly capability, they easily become stagnant--mired between fretting and guarding against further anticipated insult, and giving in to what they have convinced themselves will be inevitable humiliation and misery. This stagnancy, then, creates a secondary gain of temporary safety, as they do little to either face potentially-risky social challenges or fully confront their fears in a realistic manner. In effect, this leaves them in a mood state between anguish and woefulness, manageable only due to a modicum of awareness that it is their own creation.

Initial treatment efforts with this person should illustrate that the goals of treatment are fully achievable rather than impossible and futile. Their disconsolate manner primes them to fear that therapy may reawaken what they view as false hopes; that is, it may remind them of the disillusionment they experienced when they have aspired in the past and were rejected. Now that they may have found a modest level of comfort by distancing themselves from others, it is important therapeutically not to let matters remain at the level of depressive-anxious adjustment to which they have become accustomed. Highlighting this dilemma in a safe and empathic therapeutic environment is key to creating the platform to self-challenge and face what they initially see as cruel but inevitable fate.

Antidepressant medications or other biophysical interventions may be useful to moderate their persistent dejection and pessimism. As the therapeutic alliance is established, and medication begins to reach therapeutic levels (if used), it will be necessary to explore depressive assumptions, ruminative thought processes, self-deprecating attitudes, and other behaviors that may have evoked unhappiness, self-contempt, and derogation in the past. Acknowledging, in-session experiencing, and ultimately reframing and challenging these patterns should help reduce their sensitivity to rejection and their morose and unassertive style; outlooks and fears that only reinforce their aversive and depressive inclinations.

Consistent, focused attention will be necessary to reconstruct chronic distorted beliefs and interpersonal expectations that pervade all aspects of this person's experience. Beneficial interventions would be productively aimed at recognizing and tolerating perceived and actual slights, with particular attention paid to understanding others' motivations as separate from personal shortcomings. Along the same lines, involving more supportive family members or initiating involvement in group therapy as they are able to tolerate more immediate social challenges, could assist in moderating destructive patterns of communication that contribute to or intensify their social problems. The latter may assist them in learning new attitudes and skills in a more benign and accepting social setting than they normally encounter.

The clinician should maintain awareness that this person's depressive tendencies may serve to perpetually demean their self-worth and subject themselves to the mistreatment of others. The therapeutic alliance, in highlighting immediate interactions in-session, may be used to counteract this person's ill-disposition. Maneuvers designed to test the sincerity of the therapist will probably be evident. Because this person is likely to fear facing their feelings of unworthiness and because they sense their coping defenses are weak, an empathic but not enabling attitude will be of primary importance. The clinician should draw upon this person's strengths to prevent them from withdrawing from treatment prematurely. In this environment, they should be encouraged to explore these contradictions in their feelings and attitudes. Effective reframing may prevent the seesaw struggle between periods of temporary progress and retrogression. Genuine short-term gains will be possible, but only with careful work, a building of trust, and enhancement of their sense of self-worth.

Another important area of short-term attention is associated with this person's extensive scanning and misinterpretation of the environment. By doing this, they increase the likelihood that they will encounter the rebuffs and disappointments they wish to avoid. Moreover, their sensitive and negatively-oriented antennae pick up and intensify what most people simply overlook. Again, through experiential exposure and challenges to reinterpret their sensations, their hypersensitivity can be prevented from becoming an instrument that constantly brings to awareness the very pain they wish to escape. Reorienting their focus and negative interpretive habits to ones aimed at reducing vigilance and self-demeaning appraisals will serve to diminish rather than intensify their anguish.

End of Report

ITEM RESPONSES

1: 1	2: 1	3: 2	4: 1	5: 1	6: 2	7: 2	8: 2	9: 2	10: 2
11: 2	12: 2	13: 1	14: 1	15: 2	16: 2	17: 2	18: 1	19: 2	20: 2
21: 2	22: 2	23: 1	24: 2	25: 2	26: 1	27: 2	28: 1	29: 2	30: 1
31: 2	32: 1	33: 1	34: 1	35: 1	36: 2	37: 1	38: 2	39: 2	40: 2
41: 1	42: 2	43: 2	44: 2	45: 2	46: 2	47: 1	48: 1	49: 2	50: 2
51: 1	52: 2	53: 2	54: 2	55: 2	56: 2	57: 2	58: 2	59: 2	60: 2
61: 2	62: 1	63: 1	64: 1	65: 2	66: 2	67: 2	68: 2	69: 2	70: 2
71: 1	72: 2	73: 2	74: 2	75: 2	76: 2	77: 2	78: 2	79: 2	80: 1
81: 2	82: 2	83: 2	84: 2	85: 2	86: 2	87: 2	88: 2	89: 1	90: 1
91: 2	92: 1	93: 2	94: 2	95: 2	96: 2	97: 2	98: 2	99: 1	100: 2
101: 2	102: 2	103: 2	104: 2	105: 2	106: 2	107: 2	108: 2	109: 2	110: 2
111: 1	112: 2	113: 2	114: 1	115: 2	116: 2	117: 2	118: 2	119: 2	120: 1
121: 1	122: 1	123: 2	124: 2	125: 2	126: 2	127: 2	128: 2	129: 2	130: 2
131: 2	132: 2	133: 2	134: 2	135: 1	136: 2	137: 2	138: 2	139: 1	140: 1
141: 2	142: 2	143: 1	144: 2	145: 2	146: 2	147: 2	148: 2	149: 2	150: 2
151: 2	152: 2	153: 2	154: 2	155: 2	156: 2	157: 2	158: 1	159: 2	160: 2
161: 1	162: 2	163: 2	164: 2	165: 2	166: 2	167: 2	168: 2	169: 1	170: 1
171: 2	172: 2	173: 2	174: 2	175: 1	176: 2	177: 2	178: 2	179: 2	180: 2
181: 2	182: 2	183: 2	184: 2	185: 2	186: 2	187: 2	188: 1	189: 2	190: 2
191: 2	192: 2	193: 2	194: 2	195: 2					