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

Theodore Millon, PhD, DSc

SAMPLE

Name:	Joan Sample
ID Number:	12566
Age:	44
Gender:	Female
Setting:	Outpatient Never Hospitalized
Race:	White
Marital Status:	Divorced
Date Assessed:	02/12/2011

PEARSON

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CAPSULE SUMMARY

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

Interpretive Considerations
The client is a 44-year-old divorced white female with 15 years of education. She is currently being seen as an outpatient, and she did not identify specific problems and difficulties of an Axis I nature in the demographic portion of this test.

This patient's response style may indicate a tendency to magnify illness, an inclination to complain, or feelings of extreme vulnerability associated with a current episode of acute turmoil. The patient's scale scores may be somewhat exaggerated, and the interpretations should be read with this in mind.

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
She appears to fit the following Axis II classifications best: Borderline Personality Disorder, and Negativistic (Passive-Aggressive) Personality Disorder, with Dependent Personality Traits, and Depressive Personality Traits.

Axis I clinical syndromes are suggested by the client's MCMI-III profile in the areas of Major Depression (recurrent, severe, without psychotic features), Generalized Anxiety Disorder, and Posttraumatic Stress Disorder.

Therapeutic Considerations
Inconsistent and pessimistic, this patient may expect to be mishandled, if not harmed, even by well-intentioned therapists. Sensitive to messages of disapproval and lack of interest, she may complain excessively and be irritable and erratic in her relations with therapists. Straightforward and consistent communication may moderate her dependent/negativistic attitude. Focused, brief treatment approaches are likely to overcome her initial oppositional outlook.

SAMPLE

MILLON CLINICAL MULTIAXIAL INVENTORY - III

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INVALIDITY (SCALE V) = 0 INCONSISTENCY (SCALE W) = 4
PERSONALITY CODE: 8A 3 2B ** 2A * 8B 1 6A + 6B 5 " 7 4 ' ' // C ** - * //
SYNDROME CODE: A D ** T R * // CC ** - * //
DEMOGRAPHIC CODE: 12566/ON/F/44/W/D/15/--/--/------/4/------/

SAMPLE

CATEGORY		SCORE RAW	SCORE BR	PROFILE OF BR SCORES (0 / 60 / 75 / 85 / 115)	DIAGNOSTIC SCALES
MODIFYING INDICES	X	166	94		DISCLOSURE
	Y	4	20		DESIRABILITY
	Z	28	90		DEBASEMENT
CLINICAL PERSONALITY PATTERNS	1	15	68		SCHIZOID
	2A	20	82		AVOIDANT
	2B	21	85		DEPRESSIVE
	3	20	86		DEPENDENT
	4	7	11		HISTRIONIC
	5	12	39		NARCISSISTIC
	6A	14	65		ANTISOCIAL
	6B	14	56		SADISTIC
	7	8	15		COMPULSIVE
	8A	24	93		NEGATIVISTIC
	8B	15	70		MASOCHISTIC
SEVERE PERSONALITY PATHOLOGY	S	16	65		SCHIZOTYPAL
	C	23	93		BORDERLINE
	P	15	68		PARANOID
CLINICAL SYNDROMES	A	17	97		ANXIETY
	H	13	66		SOMATOFORM
	N	11	71		BIPOLAR: MANIC
	D	17	88		DYSTHYMIA
	B	8	68		ALCOHOL DEPENDENCE
	T	14	76		DRUG DEPENDENCE
	R	18	76		POST-TRAUMATIC STRESS
SEVERE CLINICAL SYNDROMES	SS	17	70		THOUGHT DISORDER
	CC	21	100		MAJOR DEPRESSION
	PP	7	63		DELUSIONAL DISORDER

MILLON CLINICAL MULTIAXIAL INVENTORY - III

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FACET SCORES FOR HIGHEST PERSONALITY SCALES BR 65 OR HIGHER

HIGHEST PERSONALITY SCALE BR 65 OR HIGHER: SCALE C Borderline

SCALE	SCORE RAW	SCORE BR	FACET SCALES
C.1	9	98	Temperamentally Labile
C.2	9	100	Interpersonally Paradoxical
C.3	5	79	Uncertain Self-Image

SECOND-HIGHEST PERSONALITY SCALE BR 65 OR HIGHER: SCALE 8A Negativistic (Passive-Aggressive)

SCALE	SCORE RAW	SCORE BR	FACET SCALES
8A.1	8	93	Temperamentally Irritable
8A.2	6	98	Expressively Resentful
8A.3	5	85	Discontented Self-Image

THIRD-HIGHEST PERSONALITY SCALE BR 65 OR HIGHER: SCALE 3 Dependent

SCALE	SCORE RAW	SCORE BR	FACET SCALES
3.1	8	100	Inept Self-Image
3.2	6	93	Interpersonally Submissive
3.3	4	92	Immature Representations

SAMPLE

MILLON CLINICAL MULTIAXIAL INVENTORY - III

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COMPLETE LISTING OF MCMI-III GROSSMAN FACET SCALE SCORES

		RAW	BR
1	**Schizoid**		
1.1	Temperamentally Apathetic	7	98
1.2	Interpersonally Unengaged	6	82
1.3	Expressively Impassive	5	90
2A	**Avoidant**		
2A.1	Interpersonally Aversive	7	95
2A.2	Alienated Self-Image	8	93
2A.3	Vexatious Representations	5	85
2B	**Depressive**		
2B.1	Temperamentally Woeful	7	100
2B.2	Worthless Self-Image	6	85
2B.3	Cognitively Fatalistic	7	97
3	**Dependent**		
3.1	Inept Self-Image	8	100
3.2	Interpersonally Submissive	6	93
3.3	Immature Representations	4	92
4	**Histrionic**		
4.1	Gregarious Self-Image	2	21
4.2	Interpersonally Attention-Seeking	4	43
4.3	Expressively Dramatic	0	0
5	**Narcissistic**		
5.1	Admirable Self-Image	2	15
5.2	Cognitively Expansive	2	59
5.3	Interpersonally Exploitive	6	96
6A	**Antisocial**		
6A.1	Expressively Impulsive	5	82
6A.2	Acting-Out Mechanism	5	86
6A.3	Interpersonally Irresponsible	6	98

		RAW	BR
6B	**Sadistic**		
6B.1	Temperamentally Hostile	6	97
6B.2	Eruptive Organization	5	91
6B.3	Pernicious Representations	5	88
7	**Compulsive**		
7.1	Cognitively Constricted	4	31
7.2	Interpersonally Respectful	2	20
7.3	Reliable Self-Image	3	34
8A	**Negativistic**		
8A.1	Temperamentally Irritable	8	93
8A.2	Expressively Resentful	6	98
8A.3	Discontented Self-Image	5	85
8B	**Masochistic**		
8B.1	Discredited Representations	7	98
8B.2	Cognitively Diffident	6	89
8B.3	Undeserving Self-Image	7	88
S	**Schizotypal**		
S.1	Estranged Self-Image	9	97
S.2	Cognitively Autistic	5	89
S.3	Chaotic Representations	7	98
C	**Borderline**		
C.1	Temperamentally Labile	9	98
C.2	Interpersonally Paradoxical	9	100
C.3	Uncertain Self-Image	5	79
P	**Paranoid**		
P.1	Cognitively Mistrustful	2	77
P.2	Expressively Defensive	3	84
P.3	Projection Mechanism	8	99

SAMPLE

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

RESPONSE TENDENCIES

This patient's response style may indicate a broad tendency to magnify the level of experienced illness or a characterological inclination to complain or to be self-pitying. On the other hand, the response style may convey feelings of extreme vulnerability that are associated with a current episode of acute turmoil. Whatever the impetus for the response style, the patient's scale scores, particularly those on Axis I, may be somewhat exaggerated, and the interpretation of this profile should be made with this consideration in mind.

The BR scores reported for this individual have been modified to account for the high self-revealing inclinations indicated by the high raw score on Scale X (Disclosure) and the psychic tension and dejection indicated by the elevations on Scale A (Anxiety) and Scale D (Dysthymia).

AXIS II: PERSONALITY PATTERNS

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

SAMPLE

There is reason to believe that at least a moderate level of pathology characterizes the overall personality organization of this woman. Defective psychic structures suggest a failure to develop adequate internal cohesion and a less than satisfactory hierarchy of coping strategies. This woman's foundation for effective intrapsychic regulation and socially acceptable interpersonal conduct appears deficient or incompetent. She is subjected to the flux of her own enigmatic attitudes and contradictory behavior, and her sense of psychic coherence is often precarious. She has probably had a checkered history of disappointments in her personal and family relationships. Deficits in her social attainments may also be notable as well as a tendency to precipitate self-defeating vicious circles. Earlier aspirations may have resulted in frustrating setbacks and efforts to achieve a consistent niche in life may have failed. Although she is usually able to function on a satisfactory basis, she may experience periods of marked emotional, cognitive, or behavioral dysfunction.

The MCMI-III profile of this woman suggests her marked dependency needs, deep and variable moods, and impulsive, angry outbursts. She may anxiously seek reassurance from others and is especially vulnerable to fear of separation from those who provide support, despite her frequent attempts to undo their efforts to be helpful. Dependency fears may compel her to be alternately overly compliant, profoundly gloomy, and irrationally argumentative and negativistic. Almost seeking to court undeserved blame and criticism, she may appear to find circumstances to anchor her feeling that she deserves to suffer.

She strives at times to be submissive and cooperative, but her behavior has become increasingly unpredictable, irritable, and pessimistic. She often seeks to induce guilt in others for failing her, as she sees it. Repeatedly struggling to express attitudes contrary to her feelings, she may exhibit conflicting emotions simultaneously toward others and herself, most notably love, rage, and guilt. Also notable may be her confusion over her self-image, her highly variable energy levels, easy fatigability, and her irregular sleep-wake cycle.

She is particularly sensitive to external pressure and demands, and she may vacillate between being socially agreeable, sullen, self-pitying, irritably aggressive, and contrite. She may make irrational and bitter complaints about the lack of care expressed by others and about being treated unfairly. This behavior keeps others on edge, never knowing if she will react to them in a cooperative or a sulky manner. Although she may make efforts to be obliging and submissive to others, she has learned to anticipate disillusioning relationships, and she often creates the expected disappointment by constantly questioning and doubting the genuine interest and support shown by others. Self-destructive acts and suicidal gestures may be employed to gain attention. These irritable testing maneuvers may exasperate and alienate those on whom she depends. When threatened by separation and disapproval, she may express guilt, remorse, and self-condemnation in the hope of regaining support, reassurance, and sympathy.

Beyond her helplessness and clinging behavior, she may exhibit an irritable argumentativeness. Recognizing that others may have grown weary of this behavior, she may alternate between voicing gloomy self-deprecation, being apologetic and repentant, and being petulant and bitter. A struggle between dependent acquiescence and assertive independence constantly intrudes into most relationships. Her inability to regulate her emotional controls, her feeling of being misunderstood, and her erratic moodiness contribute to innumerable wrangles and conflicts with others and to persistent tension, resentfulness, and depression.

SAMPLE

GROSSMAN PERSONALITY FACET SCALES

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

Most notable is her need for supportive signs of affection and attention from others, which is unfortunately undermined by her volatile, mercurial, and unpredictable behavior. Her behavior almost invariably elicits erratic, angry, and rejecting responses from others rather than the warmth she desires. In an unpredictable and frantic reaction to her fear of abandonment and isolation, she may become mercurially angry and explosive, hence damaging her security rather than eliciting the care she seeks. Not only does she need protection and reassurance to maintain equanimity, but she becomes inordinately vulnerable to separation from these external sources of support. Isolation may terrify her not only because she lacks a solid sense of self, but also because she is incapable of taking mature, self-determined, and independent action.

Also salient is her view of herself as weak, fragile, and inadequate to meet life's tasks competently or with ease, a generalized deficit in self-confidence that is aggravated by the habit of belittling her own abilities. Much of this self-belittling has little basis in reality. Clinically, this pattern of self-deprecation may best be conceived as a strategy by which she elicits assurances that she is worthy and loved. Hence, it serves as an instrument for evoking praise and support.

Also worthy of attention is her pattern of changing moods that shift erratically from normality to depression to excitement, with chronic feelings of dejection and apathy interspersed with brief spells of

anger, euphoria, and anxiety. The intensity of her affect and the changeability of her actions are striking. She generally fails to accord her unstable mood levels with external reality. She may exhibit a single, dominant outlook or temperament, such as a self-ingratiating depressive tone, which periodically gives way to anxious agitation or impulsive outbursts of anger or resentment. She may engage in self-destructive behavior, but she usually realizes later that her behavior was irrational and foolish.

Also noteworthy are her manifestation of purposeful inefficiency, her gratification in undermining the pleasures and expectations of others, and an overt display of intentionally contrary and oppositional behavior. Although nearly everyone behaves resentfully at times, what distinguishes this individual is the ease with which she can be provoked into acting in a resentful manner and the regularity with which she manifests procrastination, inefficiency, and obstinate behavior.

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

AXIS I: CLINICAL SYNDROMES

SAMPLE

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

Testy and demanding, this woman evinces an agitated, major depression that can be noted by her daily moodiness and vacillation. She is likely to display a rapidly shifting mix of disparaging comments about herself, anxiously expressed suicidal thoughts, and outbursts of bitter resentment interwoven with a demanding irritability toward others. Feeling trapped by constraints imposed by her circumstances and upset by emotions and thoughts she can neither understand nor control, she has turned her reservoir of anger inward, periodically voicing severe self-recrimination and self-loathing. These signs of contrition may serve to induce guilt in others, an effective manipulation in which she can give a measure of retribution without further jeopardizing what she sees as her currently precarious, if not hopeless, situation.

Failing to keep deep and powerful sources of inner conflict from overwhelming her controls, this characteristically difficult and conflicted woman may be experiencing the clinical signs of an anxiety disorder. She is unable to rid herself of preoccupations with her tension, fearful presentiments, recurring headaches, fatigue, and insomnia, and she is upset by their uncharacteristic presence in her life. Feeling at the mercy of unknown and upsetting forces that seem to well up within her, she is at a loss as to how to counteract them, but she may exploit them to manipulate others or to complain at great length.

Related to but beyond her characteristic level of emotional responsivity, this woman appears to have been confronted with an event or events in which she was exposed to a severe threat to her life, a traumatic experience that precipitated intense fear or horror on her part. Currently the residuals of this event appear to be persistently reexperienced with recurrent and distressing recollections, such as in cues that resemble or symbolize an aspect of the traumatic event. Where possible, she seeks to avoid such cues and recollections. Where they cannot be anticipated and actively avoided, as in dreams or nightmares, she may become terrified, exhibiting a number of symptoms of intense anxiety. Other signs of distress might include difficulty falling asleep, outbursts of anger, panic attacks, hypervigilance,

exaggerated startle response, or a subjective sense of numbing and detachment.

Abuse of either legal or street drugs or both is indicated in the MCMI-III protocol of this woman, who is often erratic, irritable, and negativistic. Her use of drugs may be both a statement of resentful independence from the constraints of conventional life and a means of disjoining her conflicts and liberating her uncharitable impulses toward others. An act of assertive defiance that has undertones of self-destruction, her drug abuse may be employed with a careless indifference to its consequences.

NOTEWORTHY RESPONSES

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

Health Preoccupation

1. Item Content Omitted (True)
4. Item Content Omitted (True)
55. Item Content Omitted (True)
74. Item Content Omitted (True)
75. Item Content Omitted (True)
107. Item Content Omitted (True)
130. Item Content Omitted (True)
149. Item Content Omitted (True)

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

SAMPLE

Interpersonal Alienation

10. Item Content Omitted (True)
18. Item Content Omitted (True)
27. Item Content Omitted (True)
48. Item Content Omitted (True)
69. Item Content Omitted (True)
99. Item Content Omitted (True)
161. Item Content Omitted (True)
165. Item Content Omitted (True)
174. Item Content Omitted (True)

Emotional Dyscontrol

14. Item Content Omitted (True)
22. Item Content Omitted (True)
30. Item Content Omitted (True)
34. Item Content Omitted (True)
83. Item Content Omitted (True)
96. Item Content Omitted (True)
134. Item Content Omitted (True)

Self-Destructive Potential
44. Item Content Omitted (True)
112. Item Content Omitted (True)
128. Item Content Omitted (True)
142. Item Content Omitted (True)
150. Item Content Omitted (True)
151. Item Content Omitted (True)
171. Item Content Omitted (True)

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

Childhood Abuse
132. Item Content Omitted (True)

Eating Disorder
No items endorsed.

POSSIBLE *DSM-IV®* MULTIAXIAL DIAGNOSES

SAMPLE

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

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

296.33 Major Depression (recurrent, severe, without psychotic features)
300.02 Generalized Anxiety Disorder
309.81 Posttraumatic Stress Disorder

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

Personality configuration composed of the following:

301.83 Borderline Personality Disorder
301.90 Negativistic (Passive-Aggressive) Personality Disorder
with Dependent Personality Traits
and Depressive Personality Traits

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

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

None Identified

TREATMENT GUIDE

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

SAMPLE

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.

A primary short-term goal of treatment with this patient is to aid her in reducing her intense ambivalence and growing resentment of others. With an empathic and brief focus, it should be possible to sustain a productive, therapeutic relationship. With a therapist who can convey genuine caring and firmness, she may be able to overcome her tendency to employ maneuvers to test the sincerity and motives of the therapist. Although she will be slow to reveal her resentment because she dislikes being viewed as an angry person, it can be brought into the open, if advisable, and dealt with in a kind and understanding way. She is not inclined to face her ambivalence, but her mixed feelings and attitudes must be a major focus of treatment. To prevent her from trying to terminate treatment before improvement occurs or to forestall relapses, the therapist should employ brief and circumscribed techniques to counter the patient's expectation that supportive figures will ultimately prove disillusioning.

Circumscribed interpersonal approaches (e.g., Benjamin, Kiesler) may be used to deal with the seesaw struggle enacted by the patient in her relationship with her therapist. She may alternately exhibit ingratiating submissiveness and a taunting and demanding attitude. Similarly, she may solicit the therapist's affections, but when these are expressed, she may reject them, voicing doubt about the genuineness of the therapist's feelings. The therapist may use cognitive procedures to point out these

contradictory attitudes. It is important to keep these inconsistencies in focus or the patient may appreciate the therapist's perceptiveness verbally but not alter her attitudes. Involved in an unconscious repetition-compulsion in which she recreates disillusioning experiences that parallel those of the past, the patient must not only come to recognize the expectations cognitively but may be taught to deal with their enactment interpersonally.

Despite her ambivalence and pessimistic outlook, there is good reason to operate on the premise that the patient can overcome past disappointments. To capture the love and attention only modestly gained in childhood cannot be achieved, although habits that preclude partial satisfaction can be altered in the here and now. Toward that end, the therapist must help her disentangle needs that are in opposition to one another. For example, she both wants and does not want the love of those upon whom she depends. Despite this ambivalence, she enters new relationships, such as in therapy, as if an idyllic state could be achieved. She goes through the act of seeking a consistent and true source of love, one that will not betray her as she believes her parents and others did in the past. Despite this optimism, she remains unsure of the trust she can place in others. Mindful of past betrayals and disappointments, she begins to test her new relationships to see if they are loyal and faithful. In a parallel manner, she may attempt to irritate and frustrate the therapist to check whether he or she will prove to be as fickle and insubstantial as others have in the past. It is here that the therapist's warm support and firmness can play a significant short-term role in reframing the patient's erroneous expectations and in exhibiting consistency in relationship behavior.

SAMPLE

Although the rooted character of these attitudes and behavior will complicate the ease with which these therapeutic procedures will progress, short-term and circumscribed cognitive and interpersonal therapy techniques may be quite successful. A thorough reconstruction of personality may not be necessary to alter the patient's problematic pattern. In this regard, family treatment methods that focus on the network of relationships that often sustain her problems may prove to be a useful technique. Group methods may also be fruitfully employed to help the patient acquire self-control and consistency in close relationships.

It is advisable that the therapist not set goals too high because the patient may not be able to tolerate demands or expectations well. Brief therapeutic efforts should be directed to build the patient's trust, to focus on positive traits, and to enhance her confidence and self-esteem.

End of Report

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ITEM RESPONSES

1: 1 2: 1 3: 2 4: 1 5: 2 6: 1 7: 1 8: 2 9: 2 10: 1
11: 2 12: 2 13: 1 14: 1 15: 1 16: 1 17: 2 18: 1 19: 1 20: 1
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161: 1 162: 1 163: 2 164: 1 165: 1 166: 1 167: 2 168: 2 169: 1 170: 1
171: 1 172: 2 173: 1 174: 1 175: 1

SAMPLE