



MCMII-III™
MILLON™ CLINICAL
MULTIAXIAL INVENTORY-III

Corrections Interpretive Report - Revised

MCMII-III™
Millon™ Clinical Multiaxial Inventory-III
Theodore Millon, PhD, DSc

Name: Sample Corrections Interpretive Report
ID Number: 98765
Age: 22
Gender: Female
Setting: Correctional Inmate
Race: White
Marital Status: Never Married
Date Assessed: 04/03/2009

PEARSON

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TRADE SECRET INFORMATION

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CLINICAL SUMMARY

MCCI-III reports were normed on offenders who were in the early phases of psychological screening or assessment to predict how well they would adjust to prison. Respondents who do not fit this normative correctional population or who took the MCCI-III test for other clinical purposes may receive inaccurate reports.

Note that the MCCI-III report cannot, by itself, be considered definitive. It should be evaluated in conjunction with additional clinical and biographical information. This correctional report should be evaluated by a mental health clinician who is trained in the use of psychological tests. The report should not be shown to offenders or their relatives.

Interpretive Considerations

The offender is a 22-year-old single white female with 11 years of education. She is currently being seen as a correctional offender, and she reports that she has recently experienced problems that involve her job or school and use of alcohol. These self-reported difficulties, which have occurred for an undetermined period of time, may take the form of an Axis I disorder.

Unless this offender is a well-functioning adult with only minor life stressors, her responses suggest naivete about psychological matters or a need for social approval. This interpretive report should be read with these characteristics in mind.

Profile Severity

On the basis of MCCI-III test data, it may be reasonable to assume that the offender is experiencing a problematic mental or behavioral disorder; further professional study may be advisable to assess the need for ongoing psychological care. Empirical research indicates that this offender may require mental health, substance-abuse, or anger management services.

Possible *DSM-IV*® Diagnoses

She appears to fit the following Axis II classifications best: Antisocial Personality Disorder, with Histrionic Personality Traits, Sadistic Personality Features, and Paranoid Personality Features.

Axis I clinical syndromes are suggested by the client's MCCI-III profile in the areas of Alcohol Abuse and Psychoactive Substance Abuse NOS.

If Treatment Services are Recommended

Superficially gregarious and friendly, this offender can readily become ill-humored and touchy if subjected to persistent social discomfort and external demands. She is disinclined to persevere in routine tasks such as long-term therapeutic compliance, but there may be considerable gain by using short-term behavioral management regimens that focus on specific goals and time-limited techniques.

MILLON CLINICAL MULTIAXIAL INVENTORY - III

CONFIDENTIAL INFORMATION FOR PROFESSIONAL USE ONLY

VALIDITY (SCALE V) SCORE = 0

PERSONALITY CODE: 6A ** 4 * 6B 5 8A + 7 8B 3 " 2A 1 2B ' ' // - ** - * //

SYNDROME CODE: - ** B T * // - ** - * //

DEMOGRAPHIC CODE: 98765/CI/F/22/W/N/11/JO/AL/-----/10/-----/

CATEGORY		SCORE		PROFILE OF BR SCORES				DIAGNOSTIC SCALES
		RAW	BR	0	60	75	85	
MODIFYING INDICES	X	92	59					DISCLOSURE
	Y	17	80					DESIRABILITY
	Z	4	45					DEBASEMENT
CLINICAL PERSONALITY PATTERNS	1	2	20					SCHIZOID
	2A	3	26					AVOIDANT
	2B	1	7					DEPRESSIVE
	3	6	40					DEPENDENT
	4	20	79					HISTRIONIC
	5	15	68					NARCISSISTIC
	6A	17	92					ANTISOCIAL
	6B	8	73					SADISTIC
	7	12	48					COMPULSIVE
	8A	9	60					NEGATIVISTIC
8B	4	48					MASOCHISTIC	
SEVERE PERSONALITY PATHOLOGY	S	4	60					SCHIZOTYPAL
	C	5	38					BORDERLINE
	P	9	68					PARANOID
CLINICAL SYNDROMES	A	1	12					ANXIETY
	H	0	0					SOMATOFORM
	N	7	64					BIPOLAR: MANIC
	D	4	27					DYSTHYMIA
	B	12	80					ALCOHOL DEPENDENCE
	T	11	75					DRUG DEPENDENCE
	R	0	0					POST-TRAUMATIC STRESS
SEVERE CLINICAL SYNDROMES	SS	1	9					THOUGHT DISORDER
	CC	0	0					MAJOR DEPRESSION
	PP	4	68					DELUSIONAL DISORDER

Note. Base rate transformations for the Clinical Personality Patterns scales are based on a sample of female correctional offenders.

CORRECTIONAL SUMMARY

The following classifications are based on prediction models developed as part of a research study involving over 10,000 offenders who completed the MCMI-III test at intake. The *MCMI-III Corrections Report User's Guide* summarizes this research and the validity evidence supporting these classifications. These research-based classifications are intended to assist with key programming and placement decisions made at intake.

This inmate's probable need for:	is classified as:
Mental Health Intervention	Low
Substance Abuse Treatment	High
Anger Management Services	Moderate

The statements below are relevant to offenders who have been adjudicated and recently confined to prison. These judgments are based primarily on clinical and theoretical hypotheses that derive from scores and profiles obtained on the MCMI-III test.

Reaction to Authority

This offender's surface affability is often punctuated with abrupt and confrontational outbursts. Testy and irritable, she may at times be undependable and irresponsible.

Escape Risk

This offender may not be especially trustworthy and may be willing to break out of prison if the chance arises.

Disposition to Malingering

This offender is prone to lie and deceive, and it is reasonable to assume that she may engage in slacking off and procrastinating behavior.

Response to Crowding/Isolation

Crowding and isolation are likely to be discomforting to this prisoner, but no serious untoward effects are probable under either condition.

Amenability to Treatment/Rehabilitation

This offender is not likely to share her more troublesome attitudes and personal deficiencies. Owing to the ease with which she can lose control, efforts should be made to help her learn to restrain her hostile feelings and impulsive behavior.

Suicidal Tendencies

As indicated above, the research-based, multi-scale MCMI-III prediction model classifies this offender as having a low probable need for mental health intervention. In addition, she did not answer "True" to either of the MCMI-III items that ask directly about suicidal thoughts and behaviors.

RESPONSE TENDENCIES

Unless this offender is a demonstrably well-functioning adult who is currently facing minor life stressors, her responses suggest (1) a well-established need for social approval and commendation, evident in tendencies to present herself in a favorable light, or (2) a general naivete about psychological matters, including a possible deficit in self-knowledge. The interpretation of this profile should be made with these characteristics in mind.

No adjustments were made to the BR scores of this individual to account for any undesirable response tendencies.

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.

The MCMIII profile of this woman suggests a veneer of friendliness and sociability overlying a deeper contempt for conventional morals. Although she is able to make a good impression on casual acquaintances, there is a characteristic unreliability, impulsiveness, restlessness, and moodiness that may be seen frequently by family members and close associates. There is the possibility that she is untrustworthy and unreliable, persistently seeking attention and excitement and often engaging in seductive and self-dramatizing behavior. Her relationships may be shallow and fleeting, and she may fail to meet routine responsibilities. Interactions may be disrupted by caustic comments and hostile outbursts. Not infrequently, she may act impetuously with insufficient deliberation and poor judgment. She also tends to exhibit short-lived enthusiasm followed by disillusionment and resentment at having been misled. The referring clinician may wish to corroborate these hypotheses as well as those in subsequent paragraphs.

This woman is unlikely to admit responsibility for personal or family difficulties, possessing what may be an easily circumvented conscience. Moreover, she may be quite facile in denying the presence of psychological tension or conflicts. Interpersonal problems are likely to be rationalized, especially those that she engenders, and blame may readily be projected onto others. Although she is prone to be self-indulgent and insistent on being the center of attention, she may reciprocate this attention with only minimal loyalty and affection.

When her actions are criticized or she is subjected to minor pressures or faced with potential embarrassment, she may be inclined to abandon her responsibilities, possibly with minimal guilt or remorse. Unfettered by the restrictions of social conventions or the restraints of personal loyalties, she may be quick to free herself from unwanted obligations. Her superficial affability may easily collapse, and she may be readily inclined to jettison anyone who might undermine her autonomy. Although infrequent, her temper outbursts may turn into uncontrollable rages. More typically, she is impetuous and imprudent, driven by a need for excitement and an inability to delay gratification, with minimal regard for consequences. Stimulus-seeking, she may restlessly chase one capricious whim after another, and she may have traveled an erratic course of irresponsibility, perhaps even delighting in defying social

conventions. She appears to have a poor prognosis for staying out of trouble.

AXIS I: CLINICAL SYNDROMES

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.

A reasonable probability is that alcoholism is also part of a general substance-abuse syndrome for this woman. Drinking is also part of her general pattern of hedonistic and manipulative traits. Alcohol not only enables her to pursue a variety of excitement-oriented activities but also facilitates her to indulge a range of narcissistic and socially opportunistic behavior with minimal shame and guilt. Beyond its compatibility with her stimulus-seeking and exploitive traits, alcohol may provide an outlet for her oppositional and antiauthority attitudes. Open displays of drunkenness enable her to express disdain for the limits and values of conventional society; as rebellious acts, they also flout traditional family standards and expectations. This offender's score on MCMI-III Scale B (Alcohol Dependence) is 80. Empirical research has shown that offenders scoring 75 or higher on Scale B at intake are much more likely to require prison-provided substance abuse treatment services compared to offenders scoring below 75. This research is described in the *MCMI-III Corrections Report User's Guide*.

An addictive disposition, probably involving active use of illicit or street agents, seems highly probable in this woman, who is hedonistic and exploitive. That drug use fits her recreational pattern of adolescent-like stimulus seeking and narcissistic indulgence is likely. Also consonant with her personality is the use of drugs as a symbol of disdain for conventional social values as well as an image of flouting authority that includes the posturing of independence from her family. This offender's score on MCMI-III Scale T (Drug Dependence) is 75. Empirical research has shown that offenders scoring 75 or higher on Scale T at intake are very much more likely to require prison-provided substance-abuse treatment services compared to offenders scoring below 75. This research is described in the *MCMI-III Corrections Report User's Guide*.

NOTEWORTHY RESPONSES

She 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

No items endorsed.

Interpersonal Alienation

- 48. Omitted Item (True)
- 63. Omitted Item (True)

Emotional Dyscontrol

- 14. Omitted Item (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.

Self-Destructive Potential

24. Omitted Item (True)

Childhood Abuse

No items endorsed.

Eating Disorder

No items endorsed.

POSSIBLE *DSM-IV*® MULTIAXIAL 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 MCMII-III test differ somewhat from those in the *DSM-IV*, but there are sufficient parallels in the MCMII-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 MCMII-III test. Definitive diagnoses must draw on biographical, observational, and interview data in addition to self-report inventories such as the MCMII-III test.

Axis I: Clinical Syndromes

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

305.00 Alcohol Abuse

305.90 Psychoactive Substance Abuse NOS

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 offender.

Personality configuration composed of the following:

301.70 Antisocial Personality Disorder
with Histrionic Personality Traits
Sadistic Personality Features
and Paranoid Personality Features

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 MCMII-III test, 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 individual. This information should be viewed as a guide for further investigation by the clinician.

Job or School Problems; Use of Alcohol

TREATMENT GUIDE

If additional clinical data are supportive of the MCMII-III's hypotheses, it is likely that this offender'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.

Worthy of note is the possibility of a troublesome alcohol and/or substance-abuse disorder. If verified, appropriate short-term substance-abuse services, behavioral management, or group therapy programs should be rapidly implemented.

Once this offender'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.

Essential to the success of a short-term approach with this woman is the therapist's readiness to see things from the offender's point of view and to convey a sense of trust and to create a feeling of alliance. To achieve reasonable short-term goals, this building of rapport must not be interpreted as a sign of the therapist's capitulation to the offender's bluff and arrogance. Brief treatment with her will require a balance of professional firmness and authority, mixed with tolerance for the offender's less attractive traits. By building an image of a fair-minded and strong authority figure, the therapist may successfully employ cognitive methods that will encourage the offender to change her expectations. Through reasoned and convincing comments, the therapist may provide a model for the offender to learn the mix of power, logic, and fairness.

Less confrontive cognitive approaches may provide the offender with opportunities to vent her anger, even in short-term therapy. Once drained of these hostile feelings, she may be led to examine her habitual behavior and cognitive attitudes and be guided into less destructive perceptions and outlets than before. Interpersonal methods, such as those of Benjamin and Kiesler, may provide a means to explore more socially acceptable behaviors. As far as group methods are concerned, until the offender has incorporated changed cognitions and actions, she may intrude and disrupt therapeutic functions. On the other hand, she may become a useful catalyst for short-term group interaction and gain some useful insights and a few constructive skills.

A useful short-term goal for this woman is to enable her to tolerate the experience of guilt or to accept blame for the turmoil she may cause. Cognitive methods using a measure of confrontation may help undermine her tendency to always trace problems to another person's stupidity, laziness, or hostility.

When she does accept responsibility for some of her difficulties it is important that the therapist be prepared to deal with the offender's inclination to resent the therapist for supposedly tricking her into admitting it. Similarly, the therapist should be ready to be challenged and avoid efforts to outwit her. The offender may try to set up situations to test the therapist's skills, to catch inconsistencies, to arouse ire and, if possible, to belittle and humiliate the therapist. Restraining impulses to express condemning attitudes can be a major task for the therapist, but one that can be used for positive gains, especially if tied into the application of combined cognitive (e.g., Beck, Ellis) and interpersonal interventions.

It should be noted that the precipitant for this woman's treatment is probably situational rather than internal. Hence, she is unlikely to have sought therapy voluntarily, and she may be convinced that if she were just left alone, she could work matters out on her own. Such beliefs will have to be confronted, albeit carefully. Similarly, if treatment is self-motivated, it probably was inspired by a series of legal entanglements, family problems, social humiliations, or achievement failures. Whatever its source, a firm cognitive and behavior-change approach would seem required. For this domineering and often intimidating woman, complaints are likely to be expressed in the form of irritability and restlessness. To succeed in her initial disinclination to be frank with authority figures, she may wander from one superficial topic to another. This inclination should be monitored and prevented. Moreover, contact with family members may be advisable because they may report matters quite differently than the offender. To ensure that she takes discussions seriously, she may have to be confronted directly with evidence of her contribution to her troubles. Treatment is best geared to short-term goals, reestablishing her psychic balance, and strengthening her previously adequate coping behavior with cognitive methods, unless her actions are frankly antisocial. In general, short-term approaches with this offender are best directed toward building controls rather than insights, toward the here and now rather than the past, and toward teaching her ways to sustain relationships cooperatively rather than with dominance and intimidation.

End of Report

NOTE: This and previous pages of this report contain trade secrets and are not to be released in response to requests under HIPAA (or any other data disclosure law that exempts trade secret information from release). Further, release in response to litigation discovery demands should be made only in accordance with your profession's ethical guidelines and under an appropriate protective order.

ITEM RESPONSES

1: 2	2: 1	3: 1	4: 2	5: 2	6: 1	7: 1	8: 1	9: 2	10: 2
11: 2	12: 2	13: 1	14: 1	15: 2	16: 1	17: 1	18: 2	19: 2	20: 2
21: 1	22: 2	23: 2	24: 1	25: 2	26: 2	27: 2	28: 2	29: 2	30: 2
31: 2	32: 1	33: 2	34: 2	35: 2	36: 2	37: 2	38: 2	39: 2	40: 1
41: 1	42: 2	43: 2	44: 2	45: 1	46: 2	47: 2	48: 1	49: 1	50: 2
51: 1	52: 1	53: 2	54: 1	55: 2	56: 1	57: 1	58: 2	59: 1	60: 1
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161: 2	162: 2	163: 2	164: 2	165: 2	166: 1	167: 2	168: 2	169: 2	170: 2
171: 2	172: 2	173: 2	174: 2	175: 2					