

MILLON CLINICAL MULTIAXIAL INVENTORY—III

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INTRODUCTION

The *Millon Clinical Multiaxial Inventory—III* (MCMI-III; Millon, 2006) is a 175-item True/False self-report measure of 14 personality patterns and 10 clinical syndromes for use with adults 18 years of age and older who are being evaluated and/or treated in mental health settings. Since the introduction of this test in 1977, it has become one of the most frequently used assessment instruments for the examination of personality disorders and major clinical syndromes. Only the Rorschach and MMPI-2 have produced more research within the past 5 years. There are now over 700 empirical studies based on this measure (Craig, 1993a, 1997) and eight books (Craig, 1993a, b; Craig, 2005a, b; Choca 2004; Jankowski, 2002; McCann & Dyer, 1996; Retzlaff, 1995). The test is now routinely included in texts that present chapters on major psychological tests.

HISTORY AND DEVELOPMENT

The original version of this instrument, the MCMI-I (Millon, 1983a), was developed to operationalize the theory of psychopathology introduced by Millon (1969/1983b) in *Modern Psychopathology*. In that text he proposed three axes—active–passive, pleasure–pain, self–

DON'T FORGET

- The MCMI-III is appropriate for use with adults who are being evaluated and/or treated in mental health settings.
- It was designed to detect personality disorders and a few clinical syndromes.
- It should not be used with persons who are not seeking mental health assistance (i.e., “normal” individuals).

other—as the basic building blocks of normal and abnormal personality. Conceived in terms of instrumental coping patterns designed to maximize positive reinforcements and avoid punishment, the model crossed the active–passive axis with four reinforcement strategies—detached, dependent, independent, and ambivalent—to derive eight basic personality patterns (asocial, avoidant, submissive, gregarious, narcissistic, aggressive, conforming, negativistic) and three severe variants (schizoid, cycloid, paranoid). Although Millon did not propose a formal model of clinical syndromes along with his personality taxonomy, he asserted that most or all psychiatric conditions (e.g., major depression, anxiety disorders, psychosis) could be best explained as extensions of personality.

Millon's strong theoretical interests led him to a test-development strategy that was also grounded in theory. Jane Loevinger (1957) had previously proposed that assessment instruments be built in a three-step process with theory guiding development and validation in every step. Millon used her strategy to create the MCMI-I as well as subsequent editions of the instrument.

The three steps of test development and validation described by Loevinger (1957) were called *theoretical-substantive*, *internal-structural*, and *external*. In the theoretical-substantive phase, items are generated for scales in terms of how well they conform to theory. Here Millon created an initial pool of face-valid items and then split the 1,100-item list into two equivalent forms.

For the internal-structural phase of development, scales are created to match a set of criteria defined by the theory. For example, Millon's (2006; Millon & Davis, 1996) model posits that personality scales should have high internal consistency, test-retest reliability, and a theoretically consistent pattern of correlations with other scales. During this phase, the two test forms were administered to a variety of clinical samples and Millon retained items with the highest item-total scale correlations. He then calculated item-scale intercorrelations and item endorsement frequencies and eliminated items with extreme endorsement frequencies (e.g., < 15% and > 85%). This left 440 items, which were later reduced to 289. Millon gave the experimental form of the MCMI-I to a variety of clinical patients and had 167 clinicians complete a diagnostic form for each patient they had seen for assessment or therapy. The items were then reduced to 150. Three experimental scales were eliminated and three scales were added and the validation process

previously described was then repeated until the final version contained 175 items.

For the third stage of external criterion validation, which is analogous to convergent-discriminant validity, Millon had psychiatric patients complete the final form of the MCMI-I along with several self-report measures of personality and clinical syndromes. Based on these data he judged that the scales were faithful to his theory and the test was then published with norms based on over 1,500 psychiatric patients.

The second edition of the measure, the MCMI-II (Millon, 1987), was created to keep pace with changes in the revised 3rd edition of the *Diagnostic and Statistical Manual of Mental Disorders-III-R* (DSM-III-R; American Psychiatric Association [APA], 1987). An experimental form was developed according to the model previously described totaling 368 items. Scales measuring Self-Defeating and Aggressive-Sadistic personality disorders were developed. A total of 45 items in the MCMI-I were changed and Millon introduced an item-weighting system whereby prototype items (e.g., those items essentially related to the disorder) were given higher scores. He also derived three validity scales and increased the number of personality disorder scales from 11 to 13. Validation studies were then conducted as described earlier.

The MCMI-III was developed to bring the test in line with DSM-IV (APA, 1994; see Rapid Reference 1.1). Here, 45 of the 175 items in the MCMI-II were changed, two new personality disorder scales were added to the test (depressive personality disorder and posttraumatic stress disorder), the item-weighting system was changed from a three-point to a two-point system, scales were reduced in length, and noteworthy items pertaining to child abuse and eating disorders were added but not scored on any of the scales. Significantly, Millon made sure that most test items directly reflected diagnostic criteria in the DSM-IV. The published version of the MCMI-III contains a three-item Validity index, three Modifier Indices to assess response bias, 14 personality scales, and 10 clinical syndrome scales. The personality and clinical scales contain 12 to 24 items each. Internal consistency of the scales was estimated to be between .67 and .90 using Cronbach's (1951) alpha, and test-retest stability was estimated to be between .84 and .96 over a period of 5 to 14 days (Millon, 2006, p. 76). Rapid Reference 1.2 summarizes the MCMI-III scales.

Rapid Reference 1.1

Millon Clinical Multiaxial Inventory-III

Author: Theodore Millon Ph.D.

Publication Date: 1994

What the test measures: Personality disorders and clinical syndromes

Age Range: 18 and above

Administration Time: 20–30 minutes

Qualification of examiners: Graduate training in psychodiagnostic assessment. Users of interpretive reports must meet full membership qualifications for the American Psychological Association, American Psychiatric Association, American Medical Association, or the National Association of Social Workers.

Publisher: Pearson Assessments
5601 Green Valley Drive
Bloomington, Mn 55437-1187
Phone: 800-627-7271
Fax: 800-632-9011

MCMI-III manual, \$50; profile report \$15–21.20; interpretive report, \$31.50–39.50 (2007 prices).

Item Overlap and Item Weighting

A notable feature of Millon's (2006; Millon & Davis, 1996) model of psychopathology is that various personality types and clinical syndromes are presumed to be related to one another in a predictable manner. For example, schizoid and avoidant personality styles are believed to share a trait of social detachment. This trait makes both types of individuals appear distant, withdrawn, and uneasy in social situations. In decompensated form, these personalities are thought to be prone to schizotypal and psychotic disorders.

In accordance with his model, theoretically related personality and clinical scales share certain items. The number of shared items varies across the test, but Millon (2006) identified the most defining characteristics of a scale by assigning a weight of 2 to these primary, or prototypical items, and giving a smaller weight of 1 to items that are less definitive, or nonprototypical. Thus, the central features of a personality style or clinical syndrome are weighted 2, while characteristics that are less central and defining are weighted 1. Careful

Rapid Reference 1.2

Summary of MCMI-III Scales

Validity Index

Two items measure highly improbable events designed to detect random responding and confusion.

Modifying Indexes

X. Disclosure. Scale X measures the amount of self-disclosure and willingness to admit to symptoms and problems.

Y. Desirability. Scale Y measures examinee's tendency to answer items that make one look very favorable and without problems.

Z. Debasement. Scale Z assesses examinee's tendency to answer items by accentuating, highlighting, and exaggerating problems and symptoms.

Clinical Personality Pattern Scales

1. Schizoid. Individuals are socially detached; prefer solitary activities; seem aloof, apathetic, and distant with difficulties in forming and maintaining relationships.

2A. Avoidant. Individuals are socially anxious due to perceive expectations of rejection.

2B. Depressive. Individuals are downcast and gloomy, even in the absence of a clinical depression.

3. Dependent. Individuals are passive, submissive, and feel inadequate. They generally lack autonomy and initiative.

4. Histrionic. Individuals are gregarious, with a strong need to be at the center of attention. They can be highly manipulative.

5. Narcissistic. Individuals are self-centered, exploitive, arrogant, and egotistical.

6A. Antisocial. Individuals are irresponsible, vengeful, engage in criminal behavior, and are strongly independent.

6B. Aggressive (Sadistic). Individuals are controlling and abusive; they enjoy humiliating others.

7. Compulsive. Individuals are orderly, organized, efficient, and perfectionistic. They engage in these behaviors to avoid chastisement from authority.

8A. Passive-Aggressive (Negativistic). Individuals are disgruntled, argumentative, petulant, oppositional, negativistic; they keep others on edge.

(continued)

8B. Self-Defeating. Individuals seem to engage in behaviors that result in people taking advantage of and abusing them. They act like a martyr and are self-sacrificing.

Severe Personality Pathology Scales

S. Schizotypal. Individuals seem “spacey,” self-absorbed, idiosyncratic, eccentric, and cognitively confused.

C. Borderline. Individuals display a labile affect and erratic behavior. They are emotionally intense, often dissatisfied and depressed, and may become self-destructive.

P. Paranoid. Individuals are rigid and defensive. They hold delusions of influence and persecution. They are mistrusting and may become angry and belligerent.

Clinical Syndrome Scales (Axis I Symptom Scales)

A. Anxiety Disorder. Individuals are anxious, tense, apprehensive, and physiologically overaroused.

H. Somatoform. Individuals are preoccupied with vague physical problems with no known organic cause. They tend to be hypochondriacal and somatizing.

N. Bipolar: Manic Disorder. Individuals have excessive energy and are overactive, impulsive, unable to sleep, and are manic.

D. Dysthymic Disorder. Individuals are able to maintain day-to-day functions but are depressed, pessimistic, and dysphoric. They have low self-esteem and feel inadequate.

B. Alcohol Dependence. Individuals admit to serious problems with alcohol and/or endorse personality traits often associated with abusing alcohol.

T. Drug Dependence. Individuals admit to serious problems with drugs and/or endorse personality traits often associated with abusing drugs.

R. Posttraumatic Stress Disorder. Individuals report unwanted and intrusive memories and/or nightmares of a disturbing, traumatic event; they may have flashbacks.

Severe Syndrome Scales

SS. Thought Disorder. Individuals experience thought disorder of psychotic proportions; they often report hallucinations and delusions.

CC. Major Depression. Individuals are severely depressed to the extent that they are unable to function in day-to-day activities. They have vegetative signs of clinical depression (poor appetite and sleep, low energy, loss of interests) and feel hopeless and helpless.

PP. Delusional Disorder. Individuals are acutely paranoid with delusions and irrational thinking. They may become belligerent and act out their delusions.

readers will note in the test manual (Millon, 2006) that items are given a weight of 2 only once, but may be scored 1 for one or more additional scales. This indicates that various traits and symptoms can be central to only one personality or clinical syndrome, but may overlap with other, related personalities and syndromes.

The result of item overlap on MCMI-III scales is that there are moderately high scale intercorrelations. The test manual gives a matrix of scale intercorrelations that ranges from $-.80$ to $+.85$, although most values are more modest (in the range of $-.50$ to $+.50$; Millon, 2006, Table 3.6).

DON'T FORGET

- MCMI-III scales have varying numbers of overlapping items. This creates a moderate amount of correlation between scales.
- Scale items are given a weight of 2 when they represent central, or prototypical, features of a given personality or syndrome. Less defining characteristics are given a weight of 1.

Normative Sample

The MCMI-III normative sample consisted of 998 psychiatric patients from the United States and Canada, which Millon divided into two groups for test-development purposes. The first group of 600 patients was used to create scales, and the second group of 398 patients was used for cross validation to verify accuracy of the standardized scores. Although modest in size, the normative sample represents a broad range of demographic characteristics. Patients were men (54%) and women (46%) from outpatient (52%) and inpatient (26%) settings, as well as correctional facilities (8%). The age range was 18 to 88, although 80% were between 18 and 45. Most of the patients had completed high school (82%); and among these 18% also had a college degree. A notable limitation of the sample is that most subjects were White (86%), with only a small number of Blacks (8%), Hispanics (2%), and all others (4%) represented.

Base Rate (BR) Scores

MCMI-III personality and clinical syndrome scores were standardized as BR scores rather than *T* scores. *T* scores were considered inappropriate by

Rapid Reference 1.3

What the Base Rate Scores Mean

- MCMI-III scales were standardized as base rate (BR) scores that can range from 0 to 115. BR scores reflect the prevalence of the various personality styles and clinical syndromes in the MCMI-III normative sample.
- BR scores ≥ 74 and < 85 indicate the *presence* of a clinically significant personality style or syndrome.
- BR scores > 84 indicate that a particular personality style or syndrome is *prominent* for the individual.
- BR scores of 60 represent the *median* for all patients.

Millon (2006) because they assume an underlying normal population distribution, and the MCMI-III normative sample consists of psychiatric patients. BR scores reflect the diagnoses of the individuals who make up the normative sample. For the MCMI-III, Millon had experienced clinicians provide DSM-III-R multiaxial diagnoses for all of the patients in the normative group. By knowing the scores of these patients on the MCMI-III, and their clinical diagnoses, Millon was able to create anchor points for his scales that would reflect the prevalence, or BR, of each psychiatric condition. BR scores of 60 were set at the median raw score obtained by all patients. BR scores of 75 were assigned to the minimum raw score

obtained by patients who met criteria for the particular disorder or condition. BR scores of 85 were given to the minimum raw score of patients who were judged to have a particular disorder or condition as their primary problem.

For the personality scales, BR scores of 75 to 84 signify the presence of clinically significant personality *traits*, while BR scores or above 85 suggest the presence of a *disorder*. For the clinical syndrome scales, BR scores 75 to 84 indicate the *presence* of a syndrome, and BR scores 85 or above denote the *prominence* of a particular syndrome. (See Rapid Reference 1.3.)

THEORETICAL FOUNDATION

Since the publication of MP (Millon, 1969/1983b), Millon's model of psychopathology evolved and expanded. In its current form, Millon (2006; Millon & Davis, 1996) asserts that the structure of a clinical science consists of four main elements: (1) a *theory* that explains the phenomena under observa-

tion, (2) a *taxonomy* that categorizes this phenomena into meaningful dimensions, (3) *instrumentation* that measures this phenomena, and (4) *intervention* that remediates problematic cases. Thus the MCMI-III is an instrument that measures Millon's taxonomy of classifying personality pathology, which was derived from Millon's bioevolutionary theory of personality development and pathology (Millon, 1990). Originally the MCMI was not designed to be in agreement with official psychiatric nosology and nomenclature. However, subsequent revisions of the test have brought it closer to DSM categories.

Millon's theory posits three *survival aims* or polarities in the laws of nature (Figure 1.1). The first is to maintain *existence*. At the psychological level this polarity translates into activities organized to give pleasure or enhance one's

	Existential Aim		Replication Strategy		
	Life Enhancement	Life Preservation	Reproductive Propagation	Reproductive Nurturance	
Deficiency, Imbalance, Conflict	Pleasure-Pain		Self-Other		
	Pleasure (low) Pain (low or high)	Pleasure-Pain Reversal	Self (low) Other (high)	Self (high) Other (low)	Self-Other Reversal
Adaptation Mode	Personality Disorders				
Passive: Accommodation	Schizoid (low pleasure, low pain) Depressive (high pain, low pleasure)	Masochistic	Dependent	Narcissistic	Compulsive
Active: Modification	Avoidant	Sadistic	Histrionic	Antisocial	Negativistic
Structural Pathology	Schizotypal	Borderline, Paranoid	Borderline	Paranoid	Borderline, Paranoid

Figure 1.1. Breakdown of Personality Disorders According to Millon's Model

Reprinted from Millon, T. (2006). *MCMI-III manual* (3rd ed., p. 16). Minneapolis, MN: NCS Pearson.

life or to experience pain by merely preserving life. After existence has been assured, the next organismic task is to *adapt* to one's environment. At the psychological level the adaptational polarity translates into actively changing one's environment or passively accepting and accommodating to one's circumstances of life. Finally, there is a need to *replicate* to assure survival of the species. At the psychological level, replication strategies pertain to whether one is focused primarily on one's self or on others through nurturing behaviors. Millon has recently introduced a fourth polarity, *abstraction*, but has not, as yet, developed this part of his theory.

This theory of personology development translates into a theory-based framework for both personality styles and personality pathology. Millon identified five main sources of reinforcement (independent, dependent, ambivalent, discordant, and detached) and two coping styles (active and passive). This translates into a five by two matrix of theory-derived personality disorders that closely corresponds with DSM-IV personality disorder categories; but it is not identical to it. For example, Millon's Self-Defeating and Aggressive-Sadistic personality disorders are not found in DSM-IV, but comprise styles and disorders emanating from Millon's theory.

Having developed a theory that posited the existence of certain personality disorders, Millon then developed instrumentation to assess these disorders. While he primarily used a True/False methodology in scale development for the MCMI, he is also experimenting with other assessment methodologies (e.g., diagnostic statements used for clinician ratings) as part of his instrument development. Strack (1987, 1991) has used adjective checklist methodology to assess Millon's personality styles in nonclinical populations. The theory is not tied to an assessment methodology and there may be multiple paths leading to the same assessment.

TEST ADMINISTRATION

The MCMI-III was developed for use with men and women (18 years of age and older) who are seeking mental health evaluation and/or treatment and who read at minimally the eighth-grade level. It was not meant to be used with nonclinical populations and doing so will yield distorted test results. The inventory can be administered individually or in groups using a paper-and-pencil form, or via personal computer, using a software program

available from the test publisher. Administration time is typically 20 to 30 minutes.

The test does not require special instructions for administration.

The directions printed on the answer sheet or presented via computer are sufficient for most people to accurately complete the questionnaire.

However, it is good practice for examiners to develop rapport with testing clients prior to introducing an assessment instrument. In this regard you can explain how the test will be helpful to their issues and how it will be used on their behalf. Tell clients that they will be given feedback on their test results, so it is important to answer as honestly as possible.

CAUTION

Do not test patients with the MCMI-III if they are confused, overly sedated, or intoxicated as those states will interfere with a respondent's ability to appropriately answer the questions.

Testing Individuals with Special Needs

MCMI-III administration versions are available in Spanish, on audiotape for the visually impaired, and via computer. Hearing-impaired patients should be able to take this test by reading the instructions on the test answer sheet or those provided via computer administration of the items. For patients who otherwise are unable to take this test, the examiner may read the statements aloud and have the person respond “true” or “false,” or perhaps nod his or her head to indicate the same.

Examiners who administer the test verbally to a patient must understand that they are giving the test in a manner that deviates from the way the test was standardized. Also there are interpersonal processes existing between examiner and client that are not immediately present when the client is tested without the presence of an examiner. For example, the client may be considering what the examiner will think if he or she answers the verbally presented question in a certain way. These processes may alter the way clients may respond to the items and therefore alter their scores. If there is no other way to give this test other than to read the questions to the testee, then the examiner is obligated to report this deviation in the report and to make some evaluative statement as to how the validity of the test may or may not have been affected by this kind of testing procedure.

CAUTION

The MCMI-III cannot be scored if (a) gender is not indicated, (b) age is less than 18, or (c) more than 12 items have been left unanswered.

SCORING THE MCMI-III

The test may be hand scored or computer scored using tele-scoring, mail-in answer sheets, or software for personal computers. Scoring stencils are available for handing scoring, which takes about 45 min-

utes, and are likely to lead to scoring errors due to the many adjustments that are required for this test. Because of this, Millon (2006) recommends hand scoring each test twice to minimize errors.

If the test is administered with an answer sheet instead of via computer, then, upon the client completing the test, check the answer sheet for any double-marked items and make sure that no more than 12 items have been left unanswered. If either of these conditions exist, return the answer sheet to the patient and have him or her make the necessary corrections. The MCMI-III cannot be scored if (a) the sex of the client is unknown or unspecified, (b) age is less than 18, and (c) there are 12 or more missing or double-marked items.

From Raw Scores to BR Scores

Raw scores for all scales except Disclosure (Scale X) are calculated by adding up the number of items endorsed for the scale, being careful to assign the proper weight of 1 or 2 for each item. Disclosure is a composite score calculated from the raw scores of the basic 10 personality scales, as follows:

$$\begin{aligned} \text{Disclosure} = & \text{Schizoid} + \text{Avoidant} + \text{Depressive} + \text{Dependent} + \text{Histrionic} \\ & + (\text{Narcissistic X} \cdot 67) + \text{Antisocial} + \text{Aggressive} \\ & + \text{Compulsive} + \text{Passive-Aggressive} + \text{Self-Defeating} \end{aligned}$$

The raw scores for all scales except Validity are then transformed into initial BR scores using the tables provided in Appendix C of the test manual. Millon provides separate tables for men and women. Initial BR scores are then subjected to four possible corrections designed to compensate for distortions in test scores attributable to certain biases (see Rapid Reference 1.4).

The *disclosure adjustment* was designed to counterbalance the tendency of some clients to broadly underreport or overreport personal attributes and symptoms.

Rapid Reference 1.4

Response Bias Corrections

As a means of improving diagnostic efficiency of the scales, Millon sought ways of mitigating the effects that response biases can have on the resulting profile. Following an elaborate four-step system, BR points are added or subtracted to various scale scores based on the respondent's status as inpatient or outpatient, duration of Axis I condition, level of self-disclosure, tendency to deny problems or complain excessively, and reported levels of anxiety and dysphoria. Following is a summary of corrections applied to MCMI-III BR scores.

Correction Factor	Effect on Scales
Level of Disclosure (X)	If $X > 123$, BR points are subtracted from all scales. If $X < 61$, BR points are added to all scale scores.
Anxiety-Depression	If the Anxiety and/or Dysthymia scales are elevated \geq BR 75, scores are <i>lowered</i> for Avoidant, Depressive, Self-Defeating, Schizotypal, and Borderline. The amount depends on inpatient/outpatient status and duration of Axis I condition.
Recent Inpatient Admission	When Axis I episode duration is 4 weeks or less, Thought Disorder, Major Depression, and Delusional Disorder scales are <i>increased</i> .
Denial-Complaint	When Histrionic, Narcissistic, or Compulsive come out as the highest personality scale, 8 BR points are added to that scale only.

Note: The corrections are applied in the order listed after initial BR scores have been calculated. Because some of the corrections depend upon inpatient/outpatient status and duration of Axis I episode, it is very important to properly indicate these on the test form prior to scoring.

When the raw Disclosure scale score is < 61 , points are added to the initial BR scores of all personality and clinical syndrome scales. Points are subtracted from these scales if BR is > 123 . The number of points added or subtracted is a function of how low or high the raw Disclosure scale is, and it ranges from 0 to 20.

An *anxiety/depression adjustment* was developed to correct for the inclination of patients to overreport problematic features when feeling acutely

anxious and/or depressed. A correction is made whenever Anxiety and/or Dysthymia are \geq BR 75, such that BR points are subtracted from scales Avoidant, Depressive, Self-Defeating, Schizotypal, and Borderline in proportion to (a) how elevated the scales are, (b) whether both scales are \geq 75 or just one, (c) whether the client was an inpatient at the time of testing, and (d) how recently the client developed his or her presenting problem.

The *inpatient adjustment* was created to offset the tendency of some recently hospitalized clients to underreport the severity of their emotional problems. When a client is identified as an inpatient who developed a psychiatric condition (Axis I) within the past 4 weeks, between 2 and 10 BR points are added to the Thought Disorder, Major Depression, and Delusional Disorder scales.

A *denial/complaint adjustment* is made to correct for the bias of some individuals to underreport the severity of their personality attributes. When the Histrionic, Narcissistic, or Compulsive scale is the most highly elevated among the 10 clinical personality patterns, the BR for that scale only is increased by 8 points.

Although the correction formulas are applied, in the order given, to all test protocols, it should be clear that some clients will not meet criteria for any of the corrections, while some will meet criteria for all of them. Because of this, the initial BR scores of some patients will not be altered while the scores of others will be adjusted by a considerable amount.

Computer Scoring

There are two major computerized scoring programs available to interpret the MCMI-III. The test publisher has scoring and interpretive services and will provide a narrative report written by Millon. Psychological Assessment Resources, Inc., publishes an interpretive report developed by Robert J. Craig Ph.D., ABPP. It requires that BR scores be available, either by hand scoring or by computer scoring, through the test publisher. The BR scores are then entered into the program and a narrative report is generated.

HOW TO INTERPRET THE MCMI-III

A number of sources exist for interpreting the MCMI (Craig, 1995; Craig & Plson, 1995; Millon, 1984; Retzlaff, Ofman, Hyer, & Matleson, 1994). Below is a step-by-step approach for MCMI-III interpretation.

Before interpreting the personality disorder and clinical syndrome scales, you need to (1) establish that the profile of scores is valid and, if so, (2) interpret the client's response style. The MCMI-III contains four scales

for assessing response characteristics: Validity, Disclosure, Desirability, and Debasement. Only the Validity and Disclosure scales are used to determine whether a test is interpretable or not. All four give clues about the way the client approached the test.

CAUTION

Look at and interpret the Validity Scales before examining the personality and clinical symptom scales.

Validity Index

The Validity Index (Scale V) consists of three improbable statements. If two or more of these statements are answered in the endorsed direction (e.g., true), the test is not valid. The Validity Index does not appear on the profile sheet and the psychologist must inspect the answer sheet to score this index in the hand-scored form, or refer to the printout in the mail-in scoring form. However, even if one of the items in the V is answered "true," caution should be exercised in interpreting the remainder of the test.

Disclosure (X)

The Disclosure Index (Scale X) identifies patients who are unnecessarily secretive and defensive (low scores) or openly frank and self-revealing (high scores). There are no items in this index, which is calculated from the degree of positive or negative deviation from the midrange of an adjusted composite raw score from Scales 1 through 8B. Scores below BR 34 and above 178 invalidate the profile.

Desirability (Y)

The Desirability scale (Scale Y) assesses the extent to which a respondent attempts to present himself or

DON'T FORGET

Scores < 34 and > 178 on Scale X invalidate the profile. If this occurs, do not interpret the rest of the test.

Rapid Reference 1.5

Interpreting Scale Y

- BR scores on Desirability (Y) > 74 suggest denial of psychological or personal problems. Due to computer adjustments in other scale scores, clinically elevated scores on Scale Y do not invalidate the profile.
- Elevated scores on Scale Y may be expected in some assessment contexts (e.g., custody evaluations, job retention evaluations).

herself in an overly favorable light, as morally virtuous, and as emotionally stable. Clinical interpretation begins with BR scores above 74. The higher the BR score, the more the patient is denying psychological or personal problems. Scoring adjustments are made on scales known to be affected by high scores on Scale Y. Hence elevated scores on Scale Y do not invalidate the profile. Low scores on Scale Y are not interpreted. (See Rapid Reference 1.5.)

Debasement (Z)

The Debasement scale (Scale Z) detects exaggeration of psychological problems and symptoms and the tendency to report more problems than may be objectively present. Clinically elevated scores on Scale Z may suggest a cry for help, acute emotional turmoil, or symptom exaggeration for personal gain. As with scores on Scale Y, elevated scores on Scale Z do not invalidate the profile. The MCMI-III makes scoring adjustments on scales affected by high scores on Scale Z. (See Rapid Reference 1.6.)

Although it is common to interpret the Modifier Indices individually, one

Rapid Reference 1.6

Interpreting Scale Z

BR > 74 on Scale Z suggests symptom exaggeration, a cry for help, or acute emotional turmoil. Scoring adjustments are made on MCMI-III scales affected by high scores on Scale Z. Hence, Scale Z scores do not invalidate the profile.

can also interpret their *configuration*, or their elevations in relation to one another. For example, a low score on Scale X and a high score on Scale Y might reflect a “fake-good” response set. High scores on Scale X and Scale Z might reflect a “fake-bad” response set. Low scores on Scale X and high scores on Scale Y and Scale Z suggest defensive responding (Scale X) but also the

endorsement of antithetical symptoms and traits. The examiner would need to look at the personality and clinical symptom scales to make sense of such a validity scale configuration (e.g., it might reflect manic and depressive traits and symptoms).

Clinical Personality Patterns

Schizoid

The Schizoid scale (Scale 1) is a 16-item scale that represents the passive-detached component of Millon's typology. Nine items are given a weight of 1 and seven are weighted 2. Item content pertains to detachment, lack of sexual interest, behavioral withdrawal, avoidance of relationships, emotional suppression, introverted behaviors, and feelings of emptiness, irresponsibility, and a preference for being alone. (See Rapid Reference 1.7.)

Interpretation of High Scores High-scoring patients have severe relationship deficits. They appear aloof, introverted, emotionally bland, and detached, with flat affect and an apparent low need for social contact. They have difficulties in forming and maintaining relationships and seem to prefer a solitary life. They also seem to require little affection and lack warmth and emotional expression. These patients are likely to drift through society in marginal social roles and are prone to develop Anxiety Reactions, Somatoform disorders, and Brief Reactive Psychoses, particularly when social demands become inescapable. If married or in a committed relationship, their spouse/partner is likely to complain about a lack of emotional involvement or intimacy.

Clinical Notes Some patients in psychiatric programs achieve BR scores on Scale 1 in clinically elevated ranges, suggesting the presence of schizoid traits but not necessarily a diagnosis of Schizoid Personality Disorder. Also, the presence of schizoid traits appears in some alcoholic subtypes and in some Posttraumatic Stress Disorder (PTSD) patients, but are usually associated with elevations in Scale 8A (Passive-Aggressive). Also, African-American drug addicts often score in elevated ranges on MCMI-III Scale 1, reflecting a loner type of existence where they

Rapid Reference 1.7

Interpreting Scale 1

The Schizoid Scale is measuring severe relationship deficits and restricted emotional expression.

do not want others to know their business. Also, it reflects a lack of social outlets, but probably not a Schizoid Personality Disorder.

Avoidant

The Avoidant scale (Scale 2A) is a 16-item scale that represents the *active-detached* component of Millon's typology. Eight items are weighted 1 and eight items are weighted 2. Item content pertains to feelings of rejection, avoidance of social situations, insecurities, sensitivities, and anxiety in social situations, feelings of worthlessness, anhedonia, self-blame, and expectations of criticism.

Interpretation of High Scores Patients with significant elevation of 2A are hypersensitive to rejection, both fearing and anticipating negative evaluations. Thus, they manifest a wary detachment (avoidance). Because they are quite sensitive to signs of disapproval, they tend to withdraw from or reduce social contacts. Others are able to maintain a good social appearance despite their underlying fears. Their essential conflict is a strong desire to relate socially and an equally strong expectation of disapproval, depreciation, and rejection. They may use fantasy as their main defense. They are at risk for developing social phobias.

Clinical Notes Studies have repeatedly found that many patients with major psychiatric disorders have elevated scores on 2A along with Scale 8A (Passive-Aggressive). If you see this pattern of test scores, a psychiatric evaluation may be warranted. The 2A8A/8A2A code type appears to be a very reliable marker for psychological maladjustment. (See Rapid Reference 1.8.)

Depressive

The Depressive scale (Scale 2B) is a 15-item scale that represents the *passive-detached* component of Millon's typology. Eight items are weighted 1 and seven are weighted 2. Item content pertains to self-blame, guilt, feelings of emptiness and worthlessness, pessimism, anhedonia, excessive worry over trivial matters, recurrent sadness, moodiness, and feelings of failure and admission of a previous suicide attempt.

Rapid Reference 1.8

Interpreting Scale 2A

Clinical elevations on Scale 2A, combined with elevations on Scale 8A, suggest psychological maladjustment.

Interpretation of High Scores The high-scoring patient is generally gloomy, pessimistic, overly serious,

quiet, passive, and preoccupied with negative events. These patients often feel quite inadequate and have low self-esteem. They tend to unnecessarily brood and worry, and, though they are usually responsible and conscientious, they also are 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 tend to find fault in even the most joyous experience. They feel it is futile to try to make improvements in themselves, in their relationships, or in any significant aspect of their lives because their incessant pessimism leads them toward a defeatist outlook. Their depressive demeanor often makes others around them feel guilty, since these patients are overly dependent on others for support and acceptance. They have difficulty expressing anger and aggression and perhaps displace it onto themselves. Interestingly, while their mood is often one of dejection and while their cognitions are dominated by negative thoughts, they often do not consider themselves depressed.

Clinical Notes This scale was designed to tap a depressive personality style, which is said to exist independent of a clinical depression. It is important to review elevations of Dysthymia (D) and Major Depression (CC) to ensure that elevations on 2B are not associated with a clinical depression that might abate when the clinical disorder abates. In fact, there are no items in this scale that stipulate that these personality traits occur outside an episode of major depression, though that was the intent.

Dependent

The Dependent scale (Scale 3) is a 16-item scale that assesses the passive-dependent variant in Millon’s typology. Eight items are weighted 1 and eight are weighted 2. Item content deals with traits of acquiescence, submissiveness, concerns about being abandoned, fears of being rejected, self-blame, and feelings of inadequacy, worthlessness, and insecurity.

Interpretation of High Scores These patients tend to lean on others for security, guidance, support, and direction and they seek out relationships that provide them with such emotional protection. They are passive, submissive, conforming, dependent, self-conscious, oblig-

CAUTION

Because Scale 2B is new to the MCMI-III there is little independent research as to its validity. Make sure that elevations on this scale are not due to clinical depression.

CAUTION

If the patient is clinically depressed, wait for the depression to abate before diagnosing the personality as dependent.

ing, placating, and lack initiative, confidence, and autonomy. Their temperament is pacifying and they try to avoid conflict. They have a strong need to be nurtured and they seek out relationships or institutions to take care of them. They

fear abandonment so they act in an overly compliant manner in order to ensure protection. When their security is threatened, they are prone to develop Anxiety and Depressive disorders or substance abuse disorders.

Clinical Notes Scale 3 is often elevated in patients with major psychiatric disorders. Also, patients with clinical depression may obtain elevated scores on Scale 3. These scores often abate when the depression abates. The clinician is advised to ensure that scores on Scale 3 are not a symptomatic expression of a current affective disorder.

Scale 3 shows good congruence with other self-report measures of dependence but shows low correspondence to structured psychiatric interview schedules assessing dependence.

Histrionic

The Histrionic scale (Scale 4) is a 17-item scale that represents the *active dependent* variant in Millon's typology. Ten items are weighted 1 and seven are weighted 2. Item contents address gregarious behavior, ease of social engagement and social facility, easy display of feelings, extroverted traits, flirtatious behavior, and need of excitement.

Interpretation of High Scores Clinical elevations describe a person who is overly dramatic with strong needs to be the center of attention. They tend to be seductive in thought, speech, style, dress, or manner, and seek constant stimulation, excitement, praise, and attention. They are emotionally labile, easily excited, and show frequent emotional outbursts. Outwardly they are very gregarious and outgoing but manipulate people to receive attention and approval. They can be quite socially facile and seductively engaging. However, their relationships are often shallow and strained due to their repeated dramatic and emotional outbursts and their self-centeredness. When stressed they are at risk for developing Somatoform disorders and marital problems.

Clinical Notes The character portrait just given fits well with descriptions of a Histrionic Personality Disorder. However, caution is indicated when interpreting Scale 4 as a disorder as there is ample research to suggest that elevated scores may indicate a healthy histrionic *style* but

not a disorder. The evidence is as follows: First, factor studies show that Scale 4 correlates positively with extroverted traits and behaviors and negatively with items pertaining to maladjustment. Second, convergent validity studies indicate that Scale 4 correlates positively with measures of mental health and correlates negatively with measures of emotional maladjustment. A few studies also report that elevations on Scale 4 are associated with less distress, more positive life events, and fewer social problems. Third, manifestly normal people who have been given the MCMI have often attained their highest scores on Scale 4, including Air Force Pilots in basic training, graduate students in psychology, and normal women. Fourth, except for substance abusers, Scale 4 elevations in psychiatric samples are infrequent (Craig, 1993a; 1997). Thus, the major clinical decision is to determine whether an elevation on Scale 4 (a BR score above 84) represents a histrionic style or a Histrionic Personality Disorder.

In general Scale 4 is one of the strongest scales on the MCMI with excellent reliability, but prior versions of this scale showed low correspondence with structured psychiatric interview schedules of the Histrionic Personality Disorder.

Narcissistic

The Narcissistic scale (Scale 5) is a 24-item scale, which measures the *passive-independent* component of Millon's typology. Sixteen items are weighted 1 and eight are weighted 2. Item content pertains to egocentricity, independence, grandiosity, and feelings of superiority and comfort in social situations.

Interpretations of High Scores These patients are extremely self-centered, expect others to recognize them for their special qualities, and require constant praise and admiration. They feel excessively entitled and demand social favors simply on the basis of who they are. They appear arrogant, haughty,

CAUTION

Elevations on Scale 4 may indicate a histrionic personality style rather than a Histrionic Personality Disorder.

CAUTION

The clinical task for Scale 5 is to determine if elevated scores suggest a Narcissistic Personality Disorder or a narcissistic personality style.

conceited, boastful, snobbish, pretentious, and supercilious. They can be momentarily charming but show social imperturbability and exploit social relationships for self-gain. When they experience a narcissistic injury, they are prone to develop an

affective disorder or even paranoia. Many substance-abusing patients demonstrate a Narcissistic Personality Disorder.

Clinical Notes As with Scale 4, Scale 5 has a research base that suggests that elevated scores indicate either a clinical personality disorder or a healthy adaptational personality style associated with nonclinical people. In factor-analysis studies, Scale 5 loads positively on items dealing with extroverted traits and behaviors and negatively on items pertaining to maladjustment. Scale 5 correlates moderately with indexes of mental health. It correlates negatively with all MCMI-III clinical syndrome scales and, with the exception of a substance abuse disorder, elevations on Scale 5 are rare in psychiatric samples. Many nonclinical populations attain elevated scores on Scale 5 including Air Force Pilots in basic training. On the other hand, research has also established that Scale 5 correlates positively with similar measures of pathological narcissism, especially with the Narcissistic Personality Disorder scale of the MMPI and with the Narcissistic Personality Inventory (Craig, 1993a; 1997). Thus, the clinical task is to determine whether clinically elevated scores represent a narcissistic disorder or a narcissistic personality style. Prior versions of this scale have not correlated well with structured psychiatric interview schedules.

Antisocial

The Antisocial scale (Scale 6A) is a 17-item scale that measures the active-independent component of Millon's typology. Ten items are weighted 1 and seven items are weighted 2. His theory posits that the antisocial personality style is motivated to avoid control and domination and hence a substantial number of items in the scale pertain to the issue of independence. Other item content applies to traditional antisocial indicators, such as history of truancy and delinquency, and antisocial traits and attitudes.

Interpretation of High Scores These patients are intimidating, dominating, narcissistic, aggressive, fearless, pugnacious, daring, blunt, competitive,

argumentative, self-reliant, vengeful, and harbor resentments to perceived slights. They often have an angry and hostile demeanor. Warmth, gentleness, and intimacy are viewed as a sign of weakness. They try to provoke fear in others as a way of controlling them. They use acting out as their main defense. They are prone to substance abuse, relationship difficulties, and vocational and legal problems.

Clinical Notes It is important to realize that a person can have an antisocial personality style in the absence of criminal behavior, though at the higher BR levels the absence of involvement with the criminal justice system is less likely (see Rapid Reference 1.9). Prior versions of this scale correlated moderately with similar measures of psychopathy, including both paper-and-pencil tests and with structured psychiatric interview schedules.

Aggressive / Sadistic

The Aggressive (Sadistic) scale (Scale 6B) is a 20-item scale measuring the *active-discordant* component of Millon's typology. Thirteen items are weighted 1 and seven are weighted 2. Item content includes aggressive and controlling traits.

Interpretation of High Scores These patients tend to behave abusively toward others. Traits that are descriptive of this personality style include dominating, hostile, intimidating, fearless, aggressive, hardheaded, antagonistic, arrogant, touchy, excitable, irritable, disagreeable, and angry. They use acting out as their main defense. They may react with brutal force when angered or provoked. Explosive outbursts are common. Some are able to sublimate these traits into socially approved occupations. Others may not engage in antisocial behavior but have an aggressive personality style. Patients with this personality style are prone to experience legal and marital problems.

Rapid Reference 1.9

Interpreting Scale 6A

If scores are elevated on Scale 6A, then look for evidence of criminal behavior.

CAUTION

An Aggressive-Sadistic diagnosis does not appear in DSM-IV. Patients with BR > 84 scores on Scale 6B may be diagnosed as Personality Disorder NOS, prominent aggressive traits.

Clinical Notes Look for evidence of spouse or child abuse among high-scoring patients. Also, high scores may suggest verbal rather than actual physical abuse. Prior versions of this scale showed modest correspondence with similar measures.

Compulsive

The Compulsive scale (Scale 7) is a 17-item scale that assesses the passive-ambivalent component of Millon's typology. Nine items are weighted 1 and eight items are weighted 2. Item content pertains to organized and perfectionistic behavior, impatience, good morals, obedient behavior, and suppression of emotions and rigidity.

Interpretation of High Scores These patients are behaviorally rigid, constricted, meticulous, respectful, polite, conscientious, over-conforming, and organized. They are often perfectionistic, formal, cooperative, moralistic, efficient, and flexible. They are known to suppress their strong resentment and anger toward those (usually authority figures) whose approval they seek. They generally have a repetitive lifestyle with patterned behaviors. Fear of social disapproval results in their being a model of propriety, though they may treat subordinates autocratically. They have a strong sense of duty and strive to avoid criticism. They rely on achievement and accomplishment of personal goals to feel worthwhile. Obsessional thinking may or may not be present.

Clinical Notes Although this scale was designed to measure a Compulsive Personality Disorder, there is substantial evidence to suggest that it may measure a compulsive personality style. First, Scale 7 is rarely elevated in samples of psychiatric patients. In fact it correlates positively with items pertaining to control of behavior and emotions. This is often an indicator of emotional adjustment. Second, the scale shows persistent negative correlations with measures of psychiatric disturbance. Third, nonclinical populations, including first-year seminary students, Air Force Pilots in training, family practice residents, and college students, particularly males, often score highest on Scale 7. Fourth, the scale consistently correlates with measures of mental health and negatively with measures of emotional maladjustment. Fifth, higher Scale 7 scorers often had better treatment outcomes related to improved mental health and improved self-esteem. Sixth, in the only published study featuring patients with a primary Obsessive-Compulsive Disorder, the mean BR score on Scale 7 was 56 (e.g., normal). Seventh, prior versions of this scale showed

poor convergent validity with similar measures (Craig, 1993a; 1997). The evidence summates to suggest that elevated scores may be associated with a compulsive personality style but not a compulsive disorder.

CAUTION

Scale 7 may be measuring a compulsive personality style and not a Compulsive Personality Disorder.

Passive-Aggressive (Negativistic)

The Passive-Aggressive (Negativistic) scale (Scale 8A) is a 16-item scale that assesses the *active-ambivalent* component of Millon's typology. Seven items are weighted 1 and nine are weighted 2. Item content deals with irritability, impulsivity, hostility, verbal attacks, loss of control over anger, and cruel behaviors.

Interpretation of High Scores Traits that describe this character style include moody, irritable, negativistic, hostile, grumbling, pessimistic, querulous, anxious, complaining, and disgruntled. These patients seem to be constantly disillusioned. They often feel unappreciated and sulk over feelings that they have been treated unfairly. Their continued petulance results in problems with authority, coworkers, friends, and family. High-scoring patients can be passively compliant and obedient at one moment and negativistic and oppositional at the next.

Clinical Notes Scale 8A elevation is an excellent predictor of loss of control over emotions. High scores usually suggest the presence of a serious psychiatric disorder. Prior versions of this scale showed poor correspondence with structured psychiatric interview schedules that also purportedly measured passive-aggressive behavior. One reason for this difference is the psychiatric definition of this disorder (Wetzler, Kahn, Strauman, & Dubro, 1989), which suggests that anger is expressed indirectly. Millon's concept of the term leans more toward a *negativistic character style* rather than acting in passive-aggressive ways.

Self-Defeating

The Self-Defeating scale (Scale 8B) is a 15-item scale designed to assess the *passive-discordant* component of Millon's typology. Eight items are weighted 1 and seven are weighted 2. The disorder is akin to the psychoanalytic concept of masochism. Item content pertains to acting in a self-sacrificing manner, feeling they deserve to suffer, displaying submissive behavior, placing themselves

Rapid Reference 1.10

Interpreting Scale 6B

DSM-IV does not have a diagnosis for a Self-Defeating personality disorder. To record this diagnosis, use Personality Disorder NOS, prominent self-defeating traits.

in inferior relationships, presenting mild depression, allowing oneself to be taken advantaged of, and displaying disparaging attitudes.

Interpreting High Scores These patients often allow others to take advantage of them. They behave in a self-sacrificing and martyr-like manner and seem to seek out relationships where they can acquire security

and affection in return for allowing themselves to be dominated and even abused. Look for evidence of victimization among high-scoring patients.

Clinical Notes Moderately elevated in the profiles of many psychiatric patients. Instead of connoting the characteristics associated with a self-defeating personality, I believe that high scores in such cases reflect problematic behavior patterns, which are not in the best interest of the patient. Also, look for patterns of abuse and victimization among high-scoring patients. Finally, there is very little research data with this scale on which to base definitive conclusions. (See Rapid Reference 1.10.)

Severe Personality Pathology

The personality disorders in this section measure severe forms of the basic personality patterns. Millon believes that individuals with these characteristics are prone to develop psychotic disorders, including Schizophrenia.

Schizotypal

The Schizotypal scale (Scale S) is a 16-item scale that assesses more severe structural pathology. Seven items are weighted 1 and nine are weighted 2. Item content pertains to cognitive impairments, ideas of influence, interpersonal detachment, preference for social isolation, dependent behaviors, and feeling self-conscious.

Interpretation of High Scores High-scoring patients present as emotionally bland with flat affect or with an anxious wariness. Generally they are socially detached and have a pervasive discomfort in social relationships. Accordingly they remain on the periphery of society with few or no personal attach-

ments. Thought processes may be tangential, irrelevant, or confused. They appear self-absorbed in their own thoughts. It is believed that they are prone to develop Schizophrenia if sufficiently stressed.

Clinical Notes Scale S should be one of the scales inspected when

evaluating for psychosis and major psychiatric disorders such as Schizophrenia. Unfortunately, Scale S has not demonstrated consistent clinical utility and some pathology is missed by this scale. Prior versions of this scale have shown low to moderate convergence with other measures of Schizotypal Personality Disorder.

Borderline

The Borderline scale (Scale C) is a 16-item scale with seven items weighted 1 and nine items weighted 2. Item content pertains to unstable mood, anger, guilt, obstreperous behavior and reactions, dependency-seeking behavior, erratic moods, and unstable relationships.

Interpretation of High Scores These patients show attachment disorders with patterns of intense but unstable relationships, labile emotions, a history of impulsive behaviors, and strong dependency needs with fears of abandonment. They are preoccupied with seeking emotional support and are particularly vulnerable to separation anxiety. They seem to lack a clear sense of their own identity and so they constantly seek approval, attention, and reaffirmation. They use splitting and devaluation as their main defenses. They are prone toward brief psychotic reactions and suicidal gestures. More severe cases may also self-mutilate.

Clinical Notes Scale C has been shown to be elevated in patients with many other psychiatric disorders and probably reflects erratic emotionality associated with those disorders (see Rapid Reference 1.11). There has been much research

CAUTION

Although Scale S should detect major psychiatric disorders, such as Schizophrenia, research on earlier versions of this scale suggested poor concurrent validity for Scale S.

Rapid Reference 1.11

Interpreting Scale C

Elevations of Scale C may indicate a Borderline Personality Disorder or it may suggest erratic emotionality associated with other psychiatric disorders.

($N = 22$ studies) on earlier versions of this scale. The volume of studies on this scale is sufficiently large to provide us with some tentative conclusions. In general, Scale C shows moderate to strong relationships with similar measures of the Borderline Personality Disorder.

Paranoid

The Paranoid scale (Scale P) is a 17-item scale with eight items weighted 1 and nine items weighted 2. Item content deals with ideas of control or influence, hypervigilant sensitivity, annoyance with others, delusional beliefs, grandiosity, and an edgy defensiveness.

Interpretation of High Scores The patients are vigilantly mistrustful and often perceive that people are trying to control or influence them in malevolent ways. They are characteristically abrasive, irritable, hostile, and irascible, and may also become belligerent if provoked. Their thinking is rigid and they can be argumentative. They may present with delusions of grandeur or persecution and/or ideas of reference. They use projection as their main defense.

Clinical Notes Drug addicts often obtain mildly elevated scores on Scale P. They have issues related to concerns about law breaking and getting caught, and not wanting people to know their business, so they are usually secretive. They endorse items on the MCMI pertaining to these traits, which results in some elevations on P, but they are usually not paranoid in the clinical sense. If the patient has elevations on Scale T (Drug Dependence) along with elevations on Scale P, then a clinical interview needs to determine whether there is or is not a clinical paranoia.

Prior versions of this scale suggested that Scale P bore little relationship and had low correspondence to other measures of paranoia. This was true for both self-report inventories and structured psychiatric interview schedules.

CAUTION

Earlier versions of Scale P suggested poor correspondence with other measures of Paranoia.

Clinical Syndrome Scales

Anxiety

The Anxiety Disorder scale (Scale A) is a 14-item scale with eight items

weighted 1 and six items weighted 2. It measures symptoms of generalized anxiety with item content pertaining to nervous tension, crying, indecisiveness, apprehension, and somatic complaints.

Interpretation of High Scores The high-scoring patient has symptoms associated with physiological arousal. They would be described as anxious, apprehensive, restless, and unable to relax, edgy, jittery, and indecisive. Symptoms can include complaints of insomnia, muscular tightness, headaches, nausea, cold sweats, undue perspiration, clammy hands, and palpitations. Phobias may or may not be present. High scores may meet the DSM-IV criteria for Generalized Anxiety Disorder or other anxiety-related disorders.

Clinical Notes Because of the variability of symptom expression, it is not possible to determine exactly which of the many symptoms of anxiety an individual patient has based on elevations of Scale A. However, Scale A is a strong scale and correlates well with other measures of anxiety. It is usually elevated in a number of clinical disorders, reflecting psychic distress and maladjustment. In conditions where anxiety would be expected, research has established that Scale A elevations are present. Thus, one can have a great deal of confidence when interpreting this scale. One problem, however, is that Scale A is also highly correlated with Scale D (Dysthymia). Thus the scale may not be able to distinguish between anxiety and depression. If Scale D is also elevated, then emphasize the depressive component of symptom expression. If absent, then emphasize the anxiety component if Scale A is elevated. (See Rapid Reference 1.12.)

Somatoform

The Somatoform Disorder scale (Scale H) is a 12-item scale with seven items weighted 1 and five items weighted 2. It measures elements of anxiety that may be displaced into associated physical symptoms. Item content pertains to vague bodily complaints, apprehension, crying, indecisiveness, and fatigue.

Interpretation of High Scores High-scoring patients show the persistent pursuit of medical care, even in the face of evidence that there is little,

Rapid Reference 1.12

Interpreting Scale A

The validity of Scale A is quite good, but it does not distinguish among many kinds of anxiety disorders found in DSM-IV.

if any, physical cause to their symptoms. Their physical complaints can be related to any organ system. A review of the MCMI-III Noteworthy Responses is necessary in order to determine which symptoms the patient has endorsed as present. They tend to be whiny, complaining, restless, worried, and to antagonize those closest to them with their chronic complaints of pain. Yet they tend not to respond to interventions. Their symptoms and reactions to symptoms may be developed unconsciously to gain sympathy, attention, and reassurance.

Clinical Notes High scores are usually seen among two kinds of patients: (a) Those who displace their psychological problems and/or stress into somatic channels, and (b) patients with legitimate medical problems who are coping so poorly with their illnesses that their psychological reactions are compounding the manifestation of their symptoms. In either case, these patients show persistent preoccupation with feeling in poor health and overutilization of the health care system.

This is not a well-researched scale and few, if any, studies have been directed at the kinds of patients for which this scale would be most useful (e.g., patients in medical settings). What we know about this scale comes from research using psychiatric patients.

Bipolar: Manic Disorder

The Bipolar: Manic Disorder scale (Scale N) is a 13-item scale with eight items weighted 1 and five items weighted 2. It measures hypomania and some more severe manic symptoms. The scale contains items dealing with flight of ideas, excessive energy, impulsivity, inflated self-esteem, grandiosity, and overactivity.

Interpretation of High Scores Clinically elevated scores suggest a patient with labile emotions and frequent mood swings. During the manic phase, symptoms can include flight of ideas, pressured speech, overactivity, unrealistic and expansive goals, impulsive behavior, and a demanding quality in their interpersonal relationships. Extremely high scores may also suggest psychotic processes with delusions and hallucinations.

Clinical Notes To determine if the bipolar mania is of psychotic proportions, the examiner should look for elevations in SS (Thought Disorder), PP (Delusional Disorder), or CC (Major Depression). Also, make sure that elevations from this scale are not drug-induced (see Scale T). Prior versions

of this scale had good correspondence to other measures of mania, including the MMPI Hypomania (Ma) scale.

Dysthymic Disorder

The Dysthymic Disorder scale (Scale D) is a 14-item scale with eight items weighted 1 and six items weighted 2. It measures depression of 2 or more years duration. Dysthymic patients are able to carry on day-to-day functions despite their depressed mood. Item content addresses apathy, feeling discouraged, lack of energy, crying spells, guilt, and self-deprecatory cognitions.

Interpretation of High Scores Patients scoring high on this scale are behaviorally apathetic, socially withdrawn, feel guilty, pessimistic, discouraged, and preoccupied with feelings of personal inadequacy. They have low self-esteem and utter self-deprecatory statements, feel worthless, and are persistently sad. They have many self-doubts and show introverted behavior. If physical symptoms appear, they can include problems in concentration, poor appetite, and suicidal ideation. Most do not meet the criteria for Major Depression.

Clinical Notes There are many ways to feel depressed. Not all of the previous characterizations will fit every patient who scores high on Scale D. The previous represents the prototypal Dysthymic patient. However, the individual clinician will have to do a more thorough assessment of the patient's individual symptoms of Dysthymia, which is not possible from the MCMI-III alone.

Research has indicated that Scale D was actually a better predictor of Major Depression than Scale CC (Major Depression). Scale CC had difficulty in diagnosing the disorder of Major Depression in versions MCMI-I and MCMI-II because it contained no vegetative/somatic symptoms, which are critical in distinguishing Major Depression from Dysthymia. This problem seems to have been corrected with the MCMI-III.

Previous versions of this scale showed generally moderate convergent validity with tests measuring similar constructs. Also, Scale D is highly correlated with Scale A. Thus, there is a strong element of anxiety inherent in both the construct and the scale. (See Rapid Reference 1.13.)

Rapid Reference 1.13

Interpreting Scale D

Scale D is a good measure of chronic, mild depression.

Alcohol Dependence

The Alcohol Dependence scale (Scale B) is a 15-item scale with nine items weighted 1 and six items weighted 2. Item content pertains to six items dealing directly with alcohol abuse and nine items dealing with traits often associated with problematic drinking. These include impulsivity, rationalizations, lack of adherence to societal standards, selfishness, and aggressiveness toward family members.

Interpretation of High Scores Clinically elevated scores on Scale B indicate that the patient is reporting a history of problematic drinking or personality traits frequently seen in alcoholics (Craig & Weinberg, 1992a).

Clinical Notes Studies show that Scale B correlates in the .70s with Scale T (Drug Dependence). This is no accident since people who abuse alcohol commonly also abuse illicit drugs. Hence the scale has a built-in correlation to reflect this reality.

This scale assesses alcohol dependence both directly, through items pertaining to alcohol abuse, and indirectly, through items reflecting behavior associated with problematic drinking. Thus, it is theoretically possible that a patient can endorse the latter items, obtain a high score on Scale B, and not be alcoholic. For example, if a patient endorsed all nonprototypic items, the BR score would be 79.

A clinical interview is required to determine if the patient has been abusing alcohol and, if so, in what specific areas (e.g., medical, psychological/psychiatric, social, legal, vocational, recreational, spiritual) have been affected by alcohol abuse/dependence. Earlier versions of this scale suggested it correlated with behaviors and traits associated with alcohol abuse, such as depression, dependence, anxiety, and extroversion.

Drug Dependence

The Drug Dependence scale (Scale T) is a 14-item scale with eight items weighted 1 and six items weighted 2. Item content pertains to a history of and recurrent pattern of drug abuse, disruptions in interpersonal relationships, and impulse control problems. Six items (the prototype items) assess drug abuse directly and eight assess it by evaluating for legal problems, adherence to societal standards, antisocial practices, independence, nonempathic behavior, irresponsibility, and rationalizations. These items are also associated with Antisocial Personality Disorder traits.

Interpretation of High Scores High scores suggest a person who has or had a problem with drug dependence and has personality and behavior traits associated with these problems. These include hedonism, self-indulgence, impulsivity, exploitiveness, and narcissistic personality traits. These patients are likely to be in considerable distress in social, occupational, familial, and legal areas (Craig, Bivens, & Olson, 1997; Flynn, McCann, & Fairbank, 1955; McMahon & Richards, 1996). It is theoretically possible to endorse all nonprototype items on this scale and not abuse drugs. However, this is very unlikely.

Clinical Notes Scale T correlates from .50 to .79 with Alcohol Dependence (B). This is no accident, since conceptually and clinically there is a strong relationship between people who abuse drugs and those who abuse alcohol. Hence, the scale has a built-in correlation to reflect this reality.

Research has found low concurrent validity in diagnosing drug dependence with prior versions of this scale. MCMI-I Scale T identified about one-third to one-half of known drug abusers. No research was available on the predictive accuracy of MCMI-II Scale T. Perhaps patients are able to deny their drug abuse and can conceal it from detection on the MCMI. One study did report that about 50% of drug-dependent patients, motivated to do so, are able to obtain normal values on Scale T (Craig, 1997). All research has shown that Scale T's ability to rule out drug abuse is excellent.

Earlier versions of this scale showed moderate correspondence with the MMPI MacAndrew Alcoholism Scale and other measures often associated with drug-abusing behaviors, such as extroversion, hostility, and dominance. It shows little or no relationship to measures of behavior and traits that bear no conceptual relationship to drug abuse.

Posttraumatic Stress Disorder

The Posttraumatic Stress Disorder scale (Scale R) is a new scale and was not in previous MCMI versions. It is a 16-item scale with 11 items weighted 1 and 5 items weighted 2. Item content deals with painful memories, nightmares, reports of a trauma, and flashbacks.

Interpretation of High Scores High-scoring patients are reporting symptoms that might include distressing and intrusive thoughts, flashbacks, startle responses, emotional numbing, problems in anger management, difficulties with sleep or with concentration, and psychological distress upon exposure to people, places, or events that resemble some aspect of the traumatic event.

Rapid Reference 1.14

Interpreting Scale R

Scale R was designed to detect both military and civilian trauma.

A clinical evaluation is needed to determine which symptoms are present and the degree of functional impairment (Craig & Olson, 1997; Hyer, Davis, Albrecht, Boudewyns, & Wood, 1994).

Clinical Notes If there is no trauma in the patient's history, then high

scores could suggest emotional turmoil of a nontraumatic nature.

Most PTSD scales were more specific to combat stress and may lack generalization to noncombat trauma. Scale R was constructed in such a way that it should pertain to both civilian and military trauma. (See Rapid Reference 1.14.)

Thought Disorder

The Thought Disorder scale (Scale SS) is a 17-item scale with 11 items weighted 1 and 6 items weighted 2. It measures thought disorder of a psychotic nature. Item content pertains to ideas of influence, hallucinations, delusions, slights, and intrusive thoughts.

Interpretation of High Scores Patients with elevated scores on Scale SS are admitting to thinking that is disorganized, confused, fragmented, or bizarre. Hallucinations and/or delusions may also be present. Their behavior is often withdrawn or seclusive. They often show inappropriate affect and appear confused and regressed.

Clinical Notes Research has indicated problems with Scale SS in detecting major psychoses and Schizophrenia. Prior versions of this scale indicated moderate correlations with similar measures such as the MMPI Paranoia and Schizophrenia scales.

Major Depression

The Major Depression scale (Scale CC) is a 17-item scale with 10 items weighted 1 and 7 items weighted 2. Item content deals with suicidal ideation, cognitive and vegetative signs of depression, depressed affect, crying spells, and withdrawn behavior.

Interpretation of High Scores High-scoring patients may be unable to manage their day-to-day activities. They are severely depressed, with feelings

of worthlessness and vegetative symptoms of depression (e.g., loss of energy, appetite, and weight; sleep disturbances; fatigue; loss of sexual drive or desire). Suicidal ideation may be present. Their underlying personality style is likely to be of the emotionally detached type, especially dependent or depressed.

Clinical Notes Research has clearly

established that the MCMI-I and MCMI-II Scale CC was unreliable in diagnosing Major Depression. This was because the earlier versions of the scale did not contain vegetative symptoms that are the hallmark of the disorder. Often, elevated scores on CC indicated Dysthymia or some other depression diagnosis. MCMI-III Scale CC has included a number of vegetative items to the scale, which should increase its diagnostic efficiency. Earlier versions of the scale did correlate well with similar measures, such as MMPI Scale D (Depression) and the Beck Depression Inventory.

Delusional Disorder

The item content of Delusional Disorder (Scale PP)—a 13-item scale with 9 items weighted 1 and 4 items weighted 2—deals with delusions, grandiosity, and hypervigilance. The measures of delusional thinking usually associated with a paranoid disorder.

Interpretation of High Scores Patients scoring in the clinically significant ranges on Scale PP are likely to be diagnosed with some type of paranoid disorder. They have persecutory or grandiose delusions and maintain a hostile, hypervigilant, and suspicious wariness for anticipated or perceived threats. They may also become belligerent and have irrational ideas of reference, thought influence, or thought control. The scale is thought to be a symptomatic expression of an underlying paranoid personality addressed in Scale P.

Clinical Notes Earlier versions of this scale indicated that Scale PP was weakly related to similar measures. As with Scale SS, the scale detects a delusional disorder in patients willing to admit their symptoms on the test. Some patients are able to avoid detection of their thought disorder on the MCMI.

CAUTION

Prior versions of this scale showed poor concurrent validity. The scale detected thought disorders in patients who were willing to report it but missed thought disorders among patients who were trying to conceal it.

Grossman Facet Scales

Recently, Grossman has developed facet scales for the Clinical Personality Pattern Scales based on the essential features of each personality disorder (Grossman and del Rio, 2005). Inspection of these facet scales allows the clinician to produce a more refined interpretation of the Clinical Personality Pattern Scale(s).

Development of the Facet Scales

Previously, Millon developed an organizational model that described each personality disorder according to its structural and functional domains. The model contains eight personological domains that were further divided into the categories of *behavioral* (i.e., expressive behaviors, interpersonal conduct), *phenomenological* (i.e., cognitive style, self image, mental representations), *intra-psychic* (i.e., regulatory mechanisms, morphologic organization), and *biophysical* (i.e., mood, temperament). The MCMI-III does not have items that sample all eight domains for each personality disorder. Rather it contains items that focus on the prototypal expression for each disorder.

To illustrate this concept, Millon characterized the Histrionic Personality Disorder as displaying a behavioral expression as affected, an interpersonal conduct referred to as flirtatious, a cognitive style described as flighty, object representations as shallow, a self-image as sociable, a regulatory mechanism consisting primarily of dissociation, an inchoate morphologic organization, and a fickle mood or temperament. However, the prototype histrionic disorder is more saliently described according to patients' self-image, interpersonal conduct, and expressive acts. Hence, these are the three facet subscales associated with the parent histrionic disorder scale (Scale 3).

Grossman used a five-stage process to develop facet scales for the MCMI-III. First, he identified the salient personologic domains for each MCMI-III clinical personality pattern scale. This was accomplished by consulting Millon's bioevolutionary theory as well as by examining the MCMI-III item content. He then selected items that represented the salient domains represented by these items for each MCMI-III personality scale. These preliminary scales were then given tentative names.

Next, these scales were factor analyzed and the resultant factors were in-

spected as to their relationship to the domain contained in the parent scale. At step three, the items were rationally refined based on relevance and factor loadings and then, at stage four, he calculated the alpha internal consistency coefficients for each facet subscale. Finally, BR scores were established for each MCMI-III facet subscale. The final version of these facet scales appears in the following:

Clinical Personality Pattern Scale	Grossman Facet Scales
Schizoid	Temperamentally Apathetic Interpersonally Unengaged Expressively Impassive
Avoidant	Interpersonally Aversive Alienated Self-Image Vexatious Representations
Depressive	Temperamentally Woeful Worthless Self-Image Cognitively Fatalistic
Dependent	Inept Self-Image Interpersonally Submissive Immature Representations
Histrionic	Gregarious Self-Image Interpersonally Attention-Seeking Expressively Dramatic
Narcissistic	Admirable Self-Image Cognitively Expansive Interpersonally Exploitive
Antisocial	Expressively Impulsive Acting-Out Mechanism Interpersonally Irresponsible
Sadistic (Aggressive)	Temperamentally Hostile Eruptive Organization Pernicious Representations
Compulsive	Cognitively Constricted Interpersonally Respectful Reliable Self-Image

(continued)

Clinical Personality Pattern Scale	Grossman Facet Scales
Negative (Passive-Aggressive)	Temperamentally Irritable Expressively Resentful
Masochistic (Self-Defeating)	Discontented Self-Image Discredited Representations Cognitively Diffident Undeserving Self-Image Severe Personality Pathology
Schizotypal	Estranged Self-Image Cognitively Autistic Chaotic Representations
Borderline	Temperamentally Labile Interpersonally Paradoxical Uncertain Self-Image
Paranoid	Cognitively Mistrustful Expressively Defensive Projective Mechanism

The MCMI-III was developed to capture Millon's theory of personality disorder prototypes. However, he was fully aware that there probably exist several subtypes or variations of the main prototype disorder. He has speculated on these main subtypes and provided information as to the MCMI-III scales that reflect these subtypes, as presented in the following:

Personality Disorders and Their Subtypes	MCMI-III Code Type
Schizoid	
Affectless	Scales 1, 7
Remote	Scales 1–2A/S
Languid	Scales 1–2B
Depersonalized	Scales 1–S
Avoidant	
Hypersensitive	Scales 2A–P
Self-Deserting	Scales 2A–2B
Phobic	Scales 2A–3
Conflicted	Scales 2A–8A

Personality Disorders and Their Subtypes MCMI-III Code Type

Dependent

Immature	Scale 3 (a pure type)
Ineffectual	Scales 3-1
Disquieted	Scales 3-2A
Accommodating	Scales 3-4
Selfless	Scales 3-8A

Depressive

Restive	Scales 2B-2A
Self-Derogating	Scales 2B-3
Voguish	Scales 2B-4/5
Ill-Humored	Scales 2B-8A
Morbid	Scales 2B-8B

Histrionic

Theatrical	Scale 4 (a pure type)
Appeasing	Scales 4-3
Vivacious	Scales 4-5
Disingenuous	Scales 4-6A
Tempestuous	Scales 6-8A
Infantile	Scales 4-C

Narcissistic

Elitist	Scale 5 (a pure type)
Amorous	Scales 5-4
Unprincipled	Scales 5-6A
Compensatory	Scales 5-8A/2A

Antisocial

Covetous	Scale 6A (a pure type)
Nomadic	Scales 6A-1/2A
Risk-Taking	Scales 6A-4
Reputation-Defending	Scales 6A-5
Malevolent	Scales 6A-6B/P

(continued)

Personality Disorders and Their Subtypes **MCMI-III Code Type**

Aggressive (Sadistic)

Explosive	Scale 6B (a pure type)
Spineless	Scales 6B–2A
Enforcing	Scales 6B–7
Tyrannical	Scales 6B–8A/P

Compulsive

Conscientious	Scale 7 (a pure type)
Parsimonious	Scales 7–1
Bureaucratic	Scales 7–5
Bedeviled	Scales 7–8A
Puritanical	Scales 7–P

Negativistic

Circuitious	Scales 8A–3
Vacillating	Scales 8A–C
Discontented	Scales 8A–2B
Abrasive	Scales 8A–6B

Self-Defeating

Oppressed	Scales 8B–2B
Self-Undoing	Scales 8B–3
Virtuous	Scales 8B–4
Possessive	Scales 8B–8A

Schizotypal

Inspid	Scales S–1/2B/3
Timorous	Scales S–2A/8A

Borderline

Discouraged	Scales C–2A/2B/3
Self-Destructive	Scales C–2B/8B
Impulsive	Scales C–4/6A
Petulant	Scales C–8A

Paranoid

Insular	Scales P–2A
Malignant	Scales P–6B
Obdurate	Scales P–8A
Querulous	Scales P–8A
Fanatic	Scales P–5

Demographic Variables

Most data concerning gender, race, and age come from MCMI-I studies. No information on these variables has been published for the MCMI-III. Also, when a pattern of differences does emerge, this does not necessarily imply test bias, since an alternative explanation is that the test is tapping true differences in the populations.

Also, the *diagnosis* of patients in these samples may not have changed, even when the group obtained statistically higher scores on a given scale. These facts should be taken into account when digesting the data presented in the following, which came from six studies (Craig, 1993a).

Gender

Males score higher on scale 6A; females score higher on scales H and CC. No gender effects consistently appear on scales 2 and 8A. No other conclusions are warranted from the data.

Race

Blacks consistently score higher on scales 5, 6A, P, T, and PP. Whites consistently score higher on scale D. Studies show no racial differences between blacks and whites on scales 3, 7, 8A, and A. No data is available on differences between whites and other ethnic groups on MCMI scales.

Age

No consistent patterns have been found for patient age.

Step-by-Step Procedures for Test Interpretation

Step 1: Examine the Validity Indices

- A. The test is valid if Validity Index (Scale V) = 0. Results are of questionable validity if V = 1 and are invalid if V = 2 or 3.
- B. Make sure that the Disclosure scale (Scale X) is in the valid range of BR 34 to 178.
- C. Check the Desirability scale (Scale Y) to see if the patient is understating psychopathology.
- D. Inspect the Debasement scale (Scale Z) to see if the patient is overstating psychopathology.

Next, write a paragraph describing the patient's response style using the interpretive notes presented earlier.

Step 2: Examine the Severe Personality Pathology Scales

When there are multiple scales elevated in both the clinical personality patterns and severe personality pathology scales, a general rule of thumb is to interpret scales suggesting more severe personality pathology first. Thus, if Schizotypal (Scale S), Borderline (Scale C), and/or Paranoid (Scale P) are clinically elevated, place the interpretive emphasis on these scales. Use the other elevated scales to provide associated features of the personality.

Step 3: Examine the Clinical Personality Patterns

Look for elevations in scales 1 through 8B and interpret those scales that are clinically elevated. If more than three scales are elevated at BR 75 or above, frame your interpretations using the highest two or three scales. Also, if there are multiple elevations, you might want to think about what factor or factors are driving the elevations in those scales. For example, if scales Antisocial (Scale 6A), Aggressive (Sadistic; Scale 6B), and Passive-Aggressive (Negativistic; Scale 8A) are all elevated, the anger is the emotion that permeates all these scales. If Schizoid (Scale 1), Avoidant (Scale 2A), and Dependent (Scale 3) are all elevated, the emotional detachment and passivity accounts for these combined elevations. Following this, consult the Grossman facet scales for the two or three elevated clinical personality patterns and concentrate your interpretations of those scales using the relevant elevations on the Grossman facet subscales.

Step 4: Examine the Clinical Syndrome Scales

The examiner should first interpret the severe clinical syndrome scales—Thought Disorder (Scale SS), Major Depression (Scale CC), and Delusional Disorder (Scale PP)—if the BR scores are 75 or above. Then the remaining clinical syndrome scales should be interpreted, from highest to lowest: When the BR scores are 75 or above, the examiner can diagnose the syndrome as present; when BR scores are 85 or above, the syndrome may be the primary diagnosis (i.e., the main reason the client came for help). When there is more than one scale with a BR score of 85, the highest score is the primary Axis I diagnosis.

Step 5: Interpret the Meaning of Symptoms Within the Context of the Client's Personality Style / Disorder

If a patient has a mixed Narcissistic (Scale 5) and Antisocial (Scale 6A) personality, and elevated scores on Drug Dependence (Scale T), perhaps drug abuse is part of narcissistic indulgence. Or, perhaps the patient has experi-

enced a narcissistic injury and uses drugs to quell the hurt from this perceived injury. Or, perhaps the patient is generally deviant and drug abuse is part of that overall deviance, characterized by acting out. Or, perhaps there is a deep resentment of perceived attempts to control the patient and episodes of drug abuse function as a continuing sign of “independence” and a statement that the patient will not be controlled. Whatever the reason, try to understand the meaning of the symptom in the person’s life.

Step 6: Integrate Test Findings with Other Sources of Data

The examiner must never base clinical decisions on a single source of data, but instead use multiple sources of data and then integrate test findings with ancillary information—for example, history, clinical interview, collateral information, and medical records.

STRENGTHS AND WEAKNESSES OF THE MCMI-III

A clinician should know or suspect in advance of administering the test whether the client may have a personality disorder. Other inventories often can be used with normal and nonclinical populations, whereas the MCMI-III can only be used with clinical populations. There are several characteristics of the MCMI-III that result in strengths and weaknesses relative to similar self-report inventories, as follows:

Strengths

1. *Developed from a Comprehensive Clinical Theory:* The test is an instrument derived from Millon’s (2006) comprehensive theory of psychopathology.
2. *Reflects Diagnostic Criteria Used in DSM-IV:* The test is coordinated with the multiaxial format provided in DSM-IV and is linked to its conceptual terminology and diagnostic criteria.
3. *Provides Diagnostic Accuracy:* The MCMI-III takes into account the base rates, or prevalence, of personality disorders and clinical syndromes, thereby affording the opportunity for increased diagnostic accuracy.
4. *Utilizes State-of-the-Art Validation Process:* It was developed according to Loevinger’s (1957) three-step validation process that allowed for

refinement of the test from item selection to scale development to external validation using Millon's theory as the criterion.

5. *Easy to Administer*: It is relatively quick to administer (20–30 minutes) and measures a wide range of personality traits and symptoms.

6. *Compact Design*: There is no need for a separate test booklet since items and space for the respondent's answers are on the same form.

Weaknesses

1. *Imbalance Between True and False Items*: With the vast majority of items keyed in the “true” direction, the test is susceptible to patients with an acquiescent response set (e.g., the tendency to report “true” when faced with an item that is equally true and equally false for the respondent).

2. *Pathology and Psychotic Disorder Assessments*: The test is relatively weak in assessing patients with minor personality pathology and those with psychotic disorders.

3. *Assessment of Style Versus Disorder*: The Histrionic, Narcissistic, and Compulsive scales appear to have difficulty in assessing those pathologies and seem more able to detect a histrionic, narcissistic, or compulsive personality style rather than a personality disorder.

4. *Validity Problems*: The test shows poor convergent validity with standard psychiatric rating schedules across many of its scales.

5. *Personality Subtypes Unaccounted For*: The personality disorder subtypes of a given personality disorder were not incorporated into the MCMI-III test construction and remain speculative.

6. *Sample Populations*: The normative sample is modest in size and underrepresents minority groups.

7. *Few validation Studies*: While Millon's theory provides a rich context for interpreting test results and making predictions about patient behavior, few validation studies have been conducted to verify the accuracy of these theoretical deductions.

8. *Limited Research*: While previous versions of the MCMI have been extensively researched, the MCMI-III has not, as yet, generated a similar amount of empirical studies.

CLINICAL APPLICATIONS OF THE MCMI-III

Assessment of Personality Disorders

The MCMI-III provides a very good means for rapidly assessing the presence or absence of personality disorders. It is well known that Axis II disorders can affect the course and direction of Axis I disorders (e.g., clinical disorders). Knowledge of a personality disorder within an individual patient can therefore influence treatment decisions and has relevance for predicting the patient's response to treatment. Also, personality disorders can be the focus of treatment in their own right and this diagnostic information is therefore useful in treatment planning. Of course it is also of value to learn that the patient does not have a personality disorder.

In forensic settings the MCMI-III can be useful in cases where personality disorders may be instrumentally related to a crime and also relevant at the penalty phase where personality disorders may be a mitigating factor in assigning the sentence.

Assessing Personality Style

In addition to assessing for personality manifestations at the diagnostic level, the MCMI-III can provide us with valuable information concerning the presence of personality traits that are important in understanding and treating all patients. Having this information can help us understand a patient's reaction to interventions and help to explain daily behavior patterns that may be dysfunctional.

Assessing Clinical Syndromes

The MCMI-III is able to assess most of the major (i.e., more severe) clinical syndromes in DSM-IV. While it cannot provide specificity of those syndromes (e.g., Generalized Anxiety Reaction versus Social Phobias), it does give us their categorical diagnosis (e.g., Anxiety). Research has also shown that objective diagnostic tests usually suggest the presence of clinical disorders that are occasionally missed in a clinical interview.

Assessing Severity of Disorders

Not only does the MCMI-III assess personality disorders and clinical syndromes, it is also able to reflect their severity. This knowledge is useful in a

number of settings including mental health clinics, marital therapy, criminal evaluations, and routine screening.

Assessing Treatment Outcomes

By giving the MCMI-III prior to interventions and again after treatment, the effectiveness of both pharmacological and psychosocial interventions can be assessed (Piesrma & Bies, 1997). The clinician can come to some conclusion some as to which syndromes have improved by looking at pretest and posttest scores. When doing so, keep in mind that personality disorders are relatively ingrained and should not respond to short-term intervention approaches. Note too that some change in scale scores will occur by chance and as a function of the psychometrics of the test (e.g., internal consistency and test-retest reliability of the scales).

ILLUSTRATIVE CASE REPORT

Case History

The patient was a 54-year-old, divorced, black male, tested while in an outpatient drug abuse treatment program and on methadone maintenance (with supported services), with a diagnosis of heroin dependence. Concurrently he was being treated in a program for the chronically mentally ill and carried a diagnosis of Schizophrenia, paranoid type. In addition to methadone, he was also on antipsychotic medication (Risperdal), trazadone for sleep, and Ativan for anxiety. Also, he was being treated with antihypertensive medication (Felodipine) and had Type Two Diabetes and was insulin-dependent. Associated with the latter condition was peripheral neuropathy and status, postamputation of some of his toes, and erectile dysfunction due to medical factors. He also had alcohol problems (now in remission) and was episodically attending AA. He was also positive for Hepatitis C, but had declined treatment for it.

Significantly, he had a history of murdering his girlfriend and was judged Not Guilty by Reason of Insanity (NGRI) and spent 11 years in a mental health unit at a maximum security prison. He developed his alcohol problem after his release from prison.

Currently he was living with a girlfriend, who was also dependent on heroin and was in treatment for cancer. Due to her cancer-induced pain, she found relief in heroin. The patient was buying her heroin, using funds from his public aid check, though he himself was not using heroin while on methadone maintenance. She emotionally abused him, and stole his clothes, cooking utensils, and even TV, probably to secure money for drugs. While this would upset him and while he would throw her out of his apartment, he would always take her back and the pattern would then repeat itself. In counseling the patient said he would take her back because “she is not a bad person,” and because he was lonely and needed someone to cook for him.

His behavior in the clinic indicated self-imposed isolation and behavioral withdrawal. He rarely talked with the other patients, never stayed around the clinic after receiving his medication, and never developed any friendships with other patients. Other than his treating psychiatrist and clinical psychologist, the only other significant relationship he had in his life was his abusing and abusive girlfriend.

Despite treatment with polypharmacy, he periodically reported continued difficulties with auditory hallucinations. Mostly he said these were barely audible but usually of aggressive content. They would tell him to hit people around him for no reason, so he said he would avoid people because he didn’t want to get into trouble. Occasionally these would become so compelling that he sought inpatient psychiatric hospitalization as a preventive measure and he had been hospitalized several times during his lifetime. He had been placed in a special program for the chronically mentally ill to reduce these frequent hospitalizations.

On one occasion I received a call from his girlfriend because the patient had not returned home from the clinic and was gone for over 36 hours. This was quite atypical of him and she was advised to call the police. Subsequently he was found disoriented, disheveled, with significant memory loss, and was initially diagnosed as a drug overdose. Because it was presumed to have been a suicide attempt, he was again hospitalized in an inpatient psychiatric program. Upon further investigation, it was learned that the patient had again experienced break-through auditory hallucinations and took his antipsychotic medication to no relief. He reasoned that he had not taken enough so he kept ingesting the pills in the hopes of alleviating his hallucinations. So it was ac-

tually a drug-induced psychosis, but not a suicide attempt. Figure 1.2 presents his MMI-III profile, followed by the relevant Grossman Facet scales.

Recommendations

This MCMI-III protocol will be interpreted using the recommended step-by-step described earlier in this chapter.

1. **Examine the validity (modifying) indexes:** The Validity Index was 0. He shows an above-average amount of self disclosure (Scale X), and tended to endorse items suggestive of an above-average amount of emotional turmoil (Scale Z). It is difficult to determine whether this pattern indicates an exaggeration of current problems or acute feelings of vulnerability and dysfunctionality associated with his current episode.
2. **Examine the severe personality pathology scales.** The profile of this patient shows no significant elevations on the Schizotypal (S), Borderline (C), and Paranoid (P) scales. Because of this we can use the clinical personality patterns scales for interpretation without reference to traits stemming from serious personality pathology.
3. **Interpret the clinical personality pattern scales.** The patient shows BR elevations over 85 on Schizoid (Scale 1), and Depressive (Scale 2B). Since Dysthymia (Scale D) and Major Depression (Scale CC) are also significantly elevated, I believe that the redundant items in scales D and CC, are causing the significant elevations on scale 2B. Therefore, primary interpretation will be based on the Schizoid (Scale 1) scale and on the Avoidant (Scale 2A) scale. Next, we should consult the Grossman facet subscales to accentuate the salient domains that are clinically significant. Inspection of these subscales indicates that the personality domains of temperament/mood, interpersonal behavior, expressive behaviors, and mental representations should be stressed in the personality interpretation of this patient.

Test results suggests that the patient is likely to be interpersonally introverted, expressively impassive, and likely to be seriously deficient in interpersonal skills and social relationships. He probably prefers to remain in the background and display little emotion

MILLON CLINICAL MULTIAXIAL INVENTORY - III
 CONFIDENTIAL INFORMATION FOR PROFESSIONAL USE ONLY

Valid Profile

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

SYNDROME CODE: A H T R ** D * // - ** CC * //

DEMOGRAPHIC CODE: 122/IG/M/54/B/D/13/DR/OT/V9999/10/V9999/

CATEGORY		SCORE		PROFILE OF BR SCORES				DIAGNOSTIC SCALES
		RAW	BR	0	60	75	85	
MODIFYING INDICES	X	154	88					DISCLOSURE
	Y	4	20					DESIRABILITY
	Z	26	87					DEBASEMENT
CLINICAL PERSONALITY PATTERNS	1	20	95					SCHIZOID
	2A	19	77					AVOIDANT
	2B	20	94					DEPRESSIVE
	3	11	67					DEPENDENT
	4	5	8					HISTRIONIC
	5	9	29					NARCISSISTIC
	6A	14	67					ANTISOCIAL
	6B	16	63					SADISTIC
	7	16	38					COMPULSIVE
	8A	14	69					NEGATIVISTIC
8B	13	62					MASOCHISTIC	
SEVERE PERSONALITY PATHOLOGY	S	18	73					SCHIZOTYPAL
C	12	60					BORDERLINE	
P	16	71					PARANOID	
CLINICAL SYNDROMES	A	20	108					ANXIETY
	H	16	98					SOMATOFORM
	N	10	62					BIPOLAR: MANIC
	D	16	84					DYSTHYMIA
	B	10	74					ALCOHOL DEPENDENCE
	T	18	91					DRUG DEPENDENCE
R	19	88					POST-TRAUMATIC STRESS	
SEVERE CLINICAL SYNDROMES	SS	14	67					THOUGHT DISORDER
CC	17	78					MAJOR DEPRESSION	
PP	8	64					DELUSIONAL DISORDER	

Figure I.2. MCMI-III Profile for a 54-year-old, divorced, African-American male in treatment for Chronic Mental illness and heroin dependence.

MILLON CLINICAL MULTIAXIAL INVENTORY - III
 CONFIDENTIAL INFORMATION FOR PROFESSIONAL USE ONLY

FACET SCORES FOR HIGHEST PERSONALITY SCALES BR 65 OR HIGHER

HIGHEST PERSONALITY SCALE BR 65 OR HIGHER: SCALE 1 Schizoid

SCALE	SCORE		PROFILE OF BR SCORES					FACET SCALES
	RAW	BR	0	60	70	80	90	
1.1	6	84						Temperamentally Apathetic
1.2	9	93						Interpersonally Unengaged
1.3	7	92						Expressively Impassive

SECOND HIGHEST PERSONALITY SCALE BR 65 OR HIGHER: SCALE 2B Depressive

SCALE	SCORE		PROFILE OF BR SCORES					FACET SCALES
	RAW	BR	0	60	70	80	90	
2B.1	7	99						Temperamentally Woeful
2B.2	5	77						Worthless Self-Image
2B.3	5	77						Cognitively Fatalistic

THIRD HIGHEST PERSONALITY SCALE BR 65 OR HIGHER: SCALE 2A Avoidant

SCALE	SCORE		PROFILE OF BR SCORES					FACET SCALES
	RAW	BR	0	60	70	80	90	
2A.1	8	95						Interpersonally Aversive
2A.2	6	79						Alienated Self-Image
2A.3	6	88						Vexatious Representations

Figure 1.2. (continued)

or assertiveness. He probably appears disengaged and occupies a peripheral role when in the company of others. He is quite passive and goes about his day without much pleasure. He seems unable to be enthusiastic about anything. If he is involved with female companions, it is likely that he will be quite acquiescent and deferent because of his need to be in a dependent relationship with them. His depression may simply be general apathy and anhedonia due to his personality disorder in addition to a clinical depression. On the

other hand, schizoid disorders are at risk for depressive episodes. He also seems to have underlying fears of rejection and humiliation, which is yet another reason for his emotional withdrawal.

4. **Interpret the clinical syndrome scales.** Looking first at the severe syndrome scales, Major Depression (Scale CC) is clinically elevated. This suggests difficulty in managing his day-to-day activities without emotional support. He reports a general unhappiness, at least on the test, but may be reluctant to report those feelings to others, fearing rejection or perhaps humiliation, should they disavow his feelings. More likely he turns these feelings onto himself in a depressive morose. (An inspection of his Noteworthy Responses [i.e., item endorsements] indicated an absence of endorsing items dealing with suicide.)

Both Anxiety and Posttraumatic Stress are significantly elevated. The emotion driving these two scales is anxiety, and he is likely to be experiencing a significant amount of personal distress. He is quite anxious, perhaps because he suppresses his emotions, and this makes it difficult for him to feel at ease. The Somatoform Disorder scale is also elevated, suggesting significant amounts of gastrointestinal and muscular difficulties, along with symptoms associated with emotional arousal (sweating, palpitations). Finally, the Drug Dependence Scale reflects significant problems with illicit substances.

5. **Interpret the meaning of the symptom in light of the patient's personality style.** Substance abuse may be a way of dealing with his dependence and fears of rejection as well as a way to ease his feelings of personal inadequacy. His anxiety and depression may also suggest this as well.
6. **Integrate test findings with other data sources.** This patient appears to have a Schizoid Personality Disorder, along with drug dependence, anxiety, and an affective disorder. Given the patient's history, the elevation on the Somatoform Disorder scale is probably associated with the many physical symptoms he is experiencing associated with his uncontrolled diabetes, hypertension, peripheral neuropathy, erectile dysfunction, as well as physical symptoms associated with his anxiety disorder.

One question we may ask is that, given his history, why wasn't the thought disorder scale elevated to the clinical range? The most likely

answer is that he was heavily medicated with antipsychotic medication and this may have reduced symptoms associated with psychosis.

Suggested DSM-IV Diagnoses

- I. Schizophrenia, paranoid type, episodic with interepisode residual symptoms.
Heroin dependence—on agonist therapy
Alcohol Abuse (in remission)
- II. Schizoid Personality Disorder
Hypertension
Diabetes—Type II
Peripheral Neuropathy with status/postpartial amputations of toes
Erectile Dysfunction
Hepatitis C+
- III. Problems with the primary support group (girlfriend is abusive)
Economic problems (extreme poverty)
- IV. GAF: 30

Suggested Treatment Goals

1. Maintain abstinence.
2. Maintain remission of most psychotic symptoms.
3. Reduce anxiety and depression.
4. Maintain health.
5. Help client come to a decision about his present girlfriend.

Interventions

1. Supportive psychotherapy.
2. Pharmacotherapy for psychosis, anxiety, and depression.
3. Observe for delusional thinking.

**TEST YOURSELF****1. Items for the MCMI-III were created**

- (a) to match Millon's theory.
- (b) by "dust bowl" empiricism.
- (c) to emphasize internal consistency.
- (d) by selecting items from similar tests.

2. The MCMI-III should only be used with

- (a) normal (nonclinical) clients.
- (b) patients being evaluated or treated in a mental health setting.
- (c) patients in a medical setting.
- (d) clients being evaluated for vocational preferences.

3. The MCMI-III uses a *base rate* score transformation because

- (a) these scores have better psychometric properties than other standardized scores.
- (b) personality disorders are normally distributed in the general population.
- (c) a *T* score distribution results in too high a mean to be interpreted meaningfully.
- (d) psychiatric disorders are not normally distributed.

4. *Base rate* scores

- (a) are normally distributed.
- (b) take advantage of prevalence rates of existing disorders.
- (c) are a transformed score with no evidence of utility.
- (d) cannot be used since base rates change from setting to setting.

5. For the MCMI-III, a *BR* score > 84 on a personality scale suggests

- (a) exaggeration.
- (b) defensiveness.
- (c) the patient has all of the features that define the disorder.
- (d) the patient has some of the features that define the disorder.

6. For the MCMI-III, a *BR* score > 60 but < 75 on a personality scale suggests

- (a) exaggeration.
- (b) defensiveness.
- (c) the patient has all of the features that define the disorder.
- (d) the patient has some of the features that define the disorder.

(continued)

7. Intercorrelations for MCMI-III scales are typically

- (a) lower than $\pm .25$.
- (b) in the range of $-.50$ to $+.50$.
- (c) nonsignificant.
- (d) greater than $\pm .75$.

8. The Validity index consists of

- (a) a combination of all the validity scales on the MCMI-III.
- (b) all items marked "false."
- (c) three items of an implausible nature.
- (d) items reflecting inconsistent responding.

9. A BR score on Scale X of 202 indicates

- (a) random responding.
- (b) faking good.
- (c) faking bad.
- (d) an invalid profile.

10. A BR score on Scale Y of 93 suggests

- (a) random responding.
- (b) faking good.
- (c) faking bad.
- (d) an invalid profile.

11. A BR score of 105 on Scale Z suggests

- (a) random responding.
- (b) faking good.
- (c) faking bad.
- (d) an invalid profile.

12. The author of this chapter argues that the Compulsive personality scale is

- (a) detecting primarily anger.
- (b) measuring ritualistic behaviors.
- (c) strongly influenced by a concurrent thought disorder.
- (d) measuring mostly a compulsive personality style rather than a personality disorder.

13. Patients with an Antisocial Personality Disorder often have which other concurrent personality disorder?

- (a) dependent
- (b) narcissistic
- (c) self-defeating
- (d) passive-aggressive (negativistic)

14. The Passive-Aggressive (Negativistic) personality scale measures

- (a) quarrelsome, petulance, oppositional, and antagonist behaviors.
- (b) anger expressed indirectly.
- (c) primarily dependent traits.
- (d) hopelessness, worthlessness, sadness, and depression.

15. The DSM-IV diagnosis most frequently associated with BR scores > 84 on Scale 8B is

- (a) Antisocial Personality Disorder.
- (b) Aggressive Personality Disorder.
- (c) Personality Disorder NOS, prominent aggressive traits.
- (d) None of the above.

16. Scale Z is BR = 110. The highest clinical scales are 6A and 6B, both of which are above BR 85. All clinical syndrome scales are above BR 85. The patient is applying for disability compensation. What is the most likely interpretation of this profile?**17. The patient's MCMI-III profile consists of five personality disorder scales in the clinically significant range. In this situation it would be best to _____.****18. If you suspect the patient may be psychotic, which MCMI-III scales would be most relevant for this assessment?****19. The patient is highly organized, rather meticulous and efficient, strongly motivated to meet deadlines to avoid the disapproval of superiors, and tends to suppress angry feelings. The MCMI-III personality scale most likely to be elevated is _____.****List three strengths of the MCMI-III.**

Answers: 1 = a; 2 = b; 3 = d; 4 = b; 5 = c; 6 = d; 7 = b; 8 = c; 9 = d; 10 = b; 11 = c; 12 = d; 13 = b; 14 = a; 15 = c; 16 = The patient is exaggerating his or her symptoms. Test results are not likely to accurately reflect the patient's true psychiatric state; 17 = Have the patient re-take the MCMI-III; 18 = The Severe Clinical Syndrome scales: Thought Disorder (SS), Major Depression (CC), and Delusional Disorder (PP); 19 = Compulsive; 20 = Any three of: The test was derived from Millon's theory of psychopathology; it is linked to, and coordinated with, DSM-IV; it was developed according to Loewinger's three-step validation method; it is relatively quick to administer and assesses a wide range of personality disorders and clinical syndromes; there is no need for a separate test booklet since items and space for giving responses are printed on a single form.