MCMI-III™

MILLON™ CLINICAL MULTIAXIAL INVENTORY–III

MCMI-III™

Millon™ Clinical Multiaxial Inventory-III

Interpretive Report

Theodore Millon, PhD, DSc

ID Number:	625208883
Age:	26
Gender:	Male
Setting:	Outpatient Never Hospitalized
Race:	White
Marital Status:	First Marriage
Date Assessed:	06/15/2011

Reviewed.

JONATHAN P. GORHAM, PsyD, Capt, USAF, BSC
Mental Health Flight Commander

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CAPSULE SUMMARY

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

Interpretive Considerations

The client is a 26-year-old married white male with 16 years of education. He is currently being seen as an outpatient. and he reports that he has recently experienced a problem that involves job or school. These self-reported difficulties, which have occurred for an unspecified period of time, may take the form of an Axis I disorder.

Unless this patient is a well-functioning adult who is facing minor life stressors, his responses suggest an effort to present a socially acceptable front and resistance to admitting personal shortcomings. The interpretive narrative is probably reasonably valid but may fail to represent certain features of his disorders or character.

Profile Severity

On the basis of the test data (assuming denial is not present), it may be reasonable to assume that the patient is exhibiting psychological dysfunction of mild to moderate severity. The text of the following interpretive report may need to be modulated slightly downward given this probable level of severity.

Possible Diagnoses

He appears to fit the following Axis II classifications best: Obsessive Compulsive Personality Disorder, with Histrionic Personality Traits.

The major complaints expressed by the client's MCMI-III responses do not take the form of distinct Axis I symptoms.

Therapeutic Considerations

The patient makes great efforts to be sociable and to conform to the rules of those in authority. However, there may be an undercurrent of resentment, not readily displayed, and a strong inclination to deny conflicts and a fear of losing control. Not an overt complainer, the patient will do what is expected in a therapeutic relationship. A lack of psychological-mindedness may complicate progress, but with a clearly focused and time-limited treatment regimen, there may be methods for advancing therapeutic goals.

MILLON CLINICAL MULTIAXIAL INVENTORY - III

CONFIDENTIAL INFORMATION FOR PROFESSIONAL USE ONLY

INVALIDITY (SCALE V) = 0 INCONSISTENCY (SCALE W) = 0
PERSONALITY CODE: 7 ** 4 * - + 5 3 " 1 2A 2B 6A 6B 8A 8B ' ' // - ** - * //
SYNDROME CODE: - ** - * // - ** - * //
DEMOGRAPHIC CODE: 625208883/ON/M/26/W/F/16/OT/JO/------/--/------/

CATEGORY		SCORE RAW	SCORE BR	PROFILE OF BR SCORES 0	60	75	85	115	DIAGNOSTIC SCALES
MODIFYING INDICES	X	57	29						DISCLOSURE
	Y	20	93						DESIRABILITY
	Z	0	0						DEBASEMENT
CLINICAL PERSONALITY PATTERNS	1	0	3						SCHIZOID
	2A	0	[illegible]						AVOIDANT
	[illegible]	[illegible]	[illegible]						[illegible]
	3	4	43						DEPENDENT
	4	20	75						HISTRIONIC
	5	12	59						NARCISSISTIC
	6A	0	3						ANTISOCIAL
	6B	0	3						SADISTIC
	7	25	98						COMPULSIVE
	8A	0	3						NEGATIVISTIC
	8B	0	3						MASOCHISTIC
SEVERE PERSONALITY PATHOLOGY	S	0	2						SCHIZOTYPAL
	C	0	2						BORDERLINE
	P	0	2						PARANOID
CLINICAL SYNDROMES	A	0	2						ANXIETY
	H	0	2						SOMATOFORM
	N	0	2						BIPOLAR: MANIC
	D	0	2						DYSTHYMIA
	B	0	2						ALCOHOL DEPENDENCE
	T	0	2						DRUG DEPENDENCE
	R	0	2						POST-TRAUMATIC STRESS
SEVERE CLINICAL SYNDROMES	SS	0	2						THOUGHT DISORDER
	CC	0	2						MAJOR DEPRESSION
	PP	0	2						DELUSIONAL DISORDER

RESPONSE TENDENCIES

Unless this patient is a well-functioning adult who is facing minor life stressors, his responses suggest an effort to present a socially acceptable appearance or a resistance to admitting personal shortcomings. Inclined to view psychological problems as a sign of emotional or moral weakness. the patient may protectively deny any unseemly traits or symptoms. This probably reflects either a broad-based concern about being appraised unfavorably by others or an active suspicion of the arcane motives of psychological inquiry. His MCMI-III scores have been adjusted to compensate for his defensiveness. but the overall profile may remain partially distorted. An interpretation based on standard interpretive procedures is likely to be reasonably valid but may fail to represent certain features of either the patient's current disorders or his character.

The BR scores reported for this individual have been modified to account for the low self-revealing inclinations indicated by the low raw score on Scale X (Disclosure) and the defensiveness suggested by the prominence of Personality Patterns Scale 7 (Compulsive).

AXIS II: PERSONALITY PATTERNS

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

This profile is obtained by two types of patients. The clinician reading the report must assess which group is applicable on the basis of biographical and current information. The first group includes essentially well-functioning i.e., "normal" individuals with no major personality disturbances who may be undergoing psychosocial stressors and therefore are exhibiting troublesome symptoms that are largely situational and transient. In general, these individuals are concerned with public appearances, that is, with being seen by others as composed, sociable, and conventional in their behavior. Most attempt to downplay any distressing inner emotions and try to deny troublesome relationships with others, especially in their family or personal life.

The second group of patients who show the pattern of scores obtained in this report do give evidence of personality dysfunctions. They respond to MCMI-III items as they would like others to see them, not as they are. What follows in this report assumes that the respondent is in this latter group of patients.

The MCMI-III profile of this man suggests that conformity, denial, and tension are among his most prominent features. He appears to go out of his way to adhere to the expectations of others, particularly those in authority. Especially notable is his defensiveness about admitting psychological problems. Fearing criticism and derogation, he may be self-denying and unassertive. Moreover, he may be inclined toward self-blame and self-punishment when his behavior transgresses acceptable boundaries. He denies most negative feelings, fearful that their expression might result in public condemnation. As a consequence, he often appears grim, tense, and serious. Beneath his overtly sociable, cooperative, and controlled facade, there may lie feelings of inadequacy and insecurity that he has been reasonably successful in repressing.

This man's problematic characteristic of dependent conformity is largely covered up. Because of his tendency to deny discordant attitudes and distressing feelings, this MCMI-III report may not fully disclose his current difficulties. Because he fears making mistakes, appearing unconventional, or taking risks, he narrowly restricts his behavior and feelings to those that are safe and conventional.

This man's self-doubts may motivate him to seek a supportive partner or institution, such as his place of work or his church. In this way, he may be able to associate his actions with those whose authority cannot be questioned. He tries to maintain a consistent behavioral pattern that diminishes his personal autonomy or independent thinking. Conformity to the rules and values of others is likely to be emphasized in his daily life.

He has a tendency to be overconcerned with irrelevancies, a preoccupation that serves to distract his attention from his occasional feelings of minor anxiety and inadequacy. His propriety is usually successful in restraining whatever resentment he may feel, but tensions associated with these efforts may become evident in body tightness and facial grimness. Should he engage in an overt display of hostility, he may become self-punitive as a form of symbolic expiation. Ambivalence toward those on whom he depends may intrude upon his pose of equanimity. As a result, he may have a history of persistent physical tension, possibly evident in a variety of functional or psychosomatic disorders.

AXIS I: CLINICAL SYNDROMES

No distinctive Axis I clinical syndrome appears in this man's MCMI-III diagnostic picture (other than the general personality characteristics described previously). If denial tendencies are present, he may be covering up significant symptoms.

NOTEWORTHY RESPONSES

The patient did not mark any noteworthy responses. It is possible that he is denying significant problems.

POSSIBLE *DSM-IV*® MULTIAXIAL DIAGNOSES

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

Axis I: Clinical Syndrome

The major complaints expressed by the patient do not take the form of distinct or isolated symptoms but rather appear to reflect pervasive difficulties.

Axis II: Personality Disorders
The following personality prototypes correspond to the most probable *DSM-IV* diagnoses (Disorders, Traits, Features) that characterize this patient.

Personality configuration composed of the following:

301.40 Obsessive Compulsive Personality Disorder
with Histrionic Personality Traits

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

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

Unspecified; Job or School Problems

TREATMENT GUIDE

If additional clinical data are supportive of the MCMI-III's hypotheses, it is likely that this patient's difficulties can be managed with either brief or extended therapeutic methods. The following guide to treatment planning is oriented toward issues and techniques of a short-term character, focusing on matters that might call for immediate attention, followed by time-limited procedures designed to reduce the likelihood of repeated relapses. Once this patient's more pressing or acute difficulties are adequately stabilized, attention should be directed toward goals that would aid in preventing a recurrence of problems, focusing on circumscribed issues and employing delimited methods such as those discussed in the following paragraphs.

Short-term supportive therapy may be the major initial vehicle for treating this patient. Psychopharmacologic agents may be beneficial in the early periods of this patient's difficulties but the level of dosage employed should not be such as to cause significant decrements in his efficiency and alertness. Also useful as part of a focused treatment approach are behavior modification techniques designed to desensitize the patient to currently discomforting or anxiety-provoking situations. It is unlikely that group or family therapy techniques would be notably successful in that he probably would want to ally himself with the therapist and may not participate wholeheartedly as a patient. Long-term techniques that may force him to relinquish his defenses and expose his feelings in front of others may produce an unwanted deterioration in his condition.

Among his possible reasons for seeking therapy are unanticipated attacks of anxiety, spells of immobilization, and excessive fatigue. Because symptoms such as these may threaten his public style of efficiency and responsibility, it will be especially useful to employ circumscribed and focused short-term methods of treatment. Because he may view his symptoms as products of an isolated physical disease, failing to recognize that they may represent the outcropping of his inner psychological

may be best. Certainly, for every piece of defensive armor removed, the therapist must bolster the patient's confidence twofold. To remove more defenses than the patient can tolerate may prolong the treatment plan extensively. Fortunately, he may be so well guarded that careful inquiries by the therapist may foster growth without a problematic relapse. Caution is the byword with this patient.

Owing to his anxious conformity and his fear of public ridicule, this patient may view therapy as a procedure that will expose his feelings of inadequacy. Tense, grim, and cheerless, he may prefer to maintain the status quo rather than confront the need to change. As noted above, his defensiveness should be honored, and probing and insight should proceed at a careful pace. Once a measure of trust and confidence has developed in the relationship, the therapist may use cognitive and interpersonal methods to stabilize anxieties and foster change. Because the patient prefers to restrict his actions and thoughts to those to which he is accustomed, therapeutic procedures should not confront more than he can tolerate. Goals of this nature might focus on changing assumptions, noted by Beck and others, such as the fear that any shortcoming will result in a catastrophe or that not performing at the highest level will result in a humiliating failure. Unless his problematic beliefs are explicitly addressed, he may voice pseudo-insights, especially if he is well educated, but this is often a facade to placate the therapist. His habitual defenses are so well constructed that general insight-based interpretations are likely to be temporary at best. Genuine progress necessitates brief, focused techniques to modify problematic self-statements and assumptions. Without these concrete and short-term techniques, he will pay lip service to treatment goals, expressing guilt and self-condemnation for his past shortcoming, but he may not readily relinquish his defensive controls. Empathy alone may likewise be only modestly useful because of his evasiveness and his discomfort with emotion-laden materials. Owing to his need to follow a rigid and formalized lifestyle, he is likely to respond better to short-term cognitive or interpersonal methods that are specific in their procedures rather than to more expressive or nondirective techniques. To diminish the occurrence of setbacks, efforts should be made to strengthen his will to give up maladaptive beliefs such as unrelenting self-criticism and the unyielding correctness of authority-based rules and regulations.

End of Report

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MM

ITEM RESPONSES

1: 2 2: 1 3: 2 4: 2 5: 2 6: 2 7: 2 8: 2 9: 2 10: 2
11: 2 12: 1 13: 2 14: 2 15: 2 16: 2 17: 2 18: 2 19: 2 20: 2
21: 2 22: 2 23: 1 24: 2 25: 2 26: 2 27: 2 28: 2 29: 1 30: 2
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161: 2 162: 2 163: 2 164: 2 165: 2 166: 2 167: 2 168: 2 169: 2 170: 2
171: 2 172: 1 173: 2 174: 2 175: 2

Instructions

Fill in the missing letter, number, or word to complete each sequence. Write only one character in each blank space. Please press hard when marking your responses.

Shipley-2

Abstraction

AutoScore™ Form

Christian P. Gruber, Ph.D.

Name: PATRICK BURKE

Age: 26

Date: 15 JUN 11

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Examples: big little high low cold ___ 1 3 5 ___ 9

big little high low cold h o t 1 3 5 7 9

1. 1 2 3 4 5 6
2. white black short long down u p
3. AB BC CD D E
4. 10 1 9 2 8 3
5. A Z B Y C X D W
6. oh ho rat tar mood d o o m
7. escape scape cape a p e
8. mist is wasp as pint in tone o n
9. NE/SW SE/NW E/W N/ S
10. 12321 23432 34543 456 5 4
11. knit in spud up both to stay a t
12. 57326 73265 32657 26573 6 5 7 3 2
13. Scotland landscape scapegoat g o a t ee
14. 3 7 5 11 2 5
15. tam tan rib rid rat raw hip h i ___
16. G V J T M R P P
17. surgeon 1234567 snore 17635 rogue 3 6 4 2 5
18. 4 11 7 20 3 8
19. two w four r one o three R
20. thicken 10 founder 4 nectarine 7
21. 3124 82 73 154 46 13 6
22. K W M S P P T N L B
23. pole post mail carton box fight film picture depict money C h a n g e alter
24. 9 6 12 7 3 ___
25. trauma tuna flight fit wife w a ___ e glossy gravity

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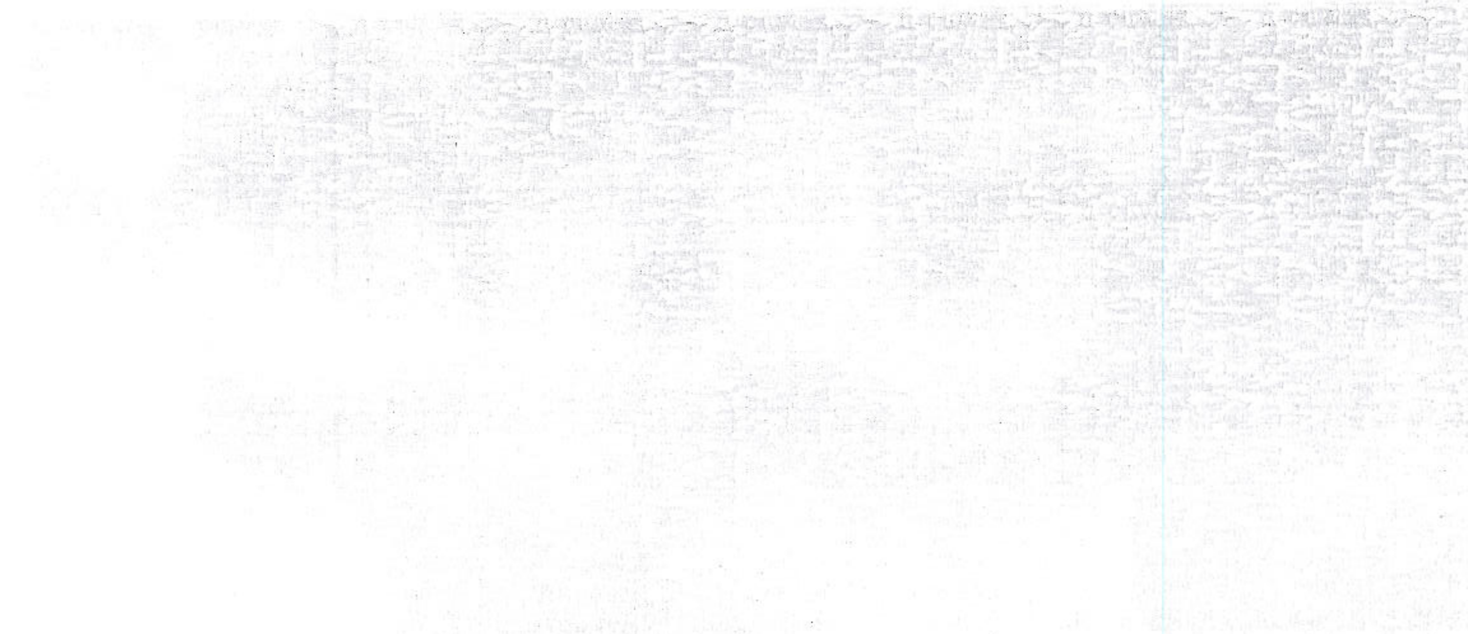

Instructions

Circle the word that has the same meaning as the one written in capital letters. If you want to change an answer, draw an X through your first answer and then circle your new choice. Please press hard when marking your responses.

Shipley-2

Vocabulary

AutoScore™ Form

Walter C. Shipley, Ph.D., and
Christian P. Gruber, Ph.D.

Name: PATRICK BURKE

Age: 26

Date: 15 Jan 11

Example	LARGE	red	big	silent	wet
1.	TALK	draw	eat	speak	sleep
2.	COUCH	pin	eraser	sofa	glass
3.	REMEMBER	swim	recall	number	plan
4.	PARDON	forgive	pound	divide	crash
5.	HIDEOUS	silvery	tilted	young	dreadful
6.	MASSIVE	bright	large	speedy	low
7.	PROBABLE	likely	portable	friendly	comprehensive
8.	IMPOSTOR	conductor	officer	book	pretender
9.	FASCINATE	welcome	fix	stir	enchant
10.	EVIDENT	green	obvious	skeptical	afraid
11.	NARRATE	yield	buy	associate	tell
12.	HAUL	respond	twist	pull	realize
13.	HILARITY	laughter	speed	grace	malice
14.	IGNORANT	red	sharp	uninformed	precise
15.	CAPTION	drum	ballast	heading	ape
16.	INDICATE	defy	excite	signify	bicker
17.	SOLEMN	serious	satisfying	rough	tremendous
18.	FORTIFY	submerge	strengthen	vent	deaden
19.	MERIT	deserve	distrust	fight	separate
20.	RENOWN	length	head	fame	loyalty
21.	FACILITATE	turn	help	strip	bewilder
22.	AMULET	charm	orphan	dingo	pond
23.	STERILE	barren	illegal	helpless	tart
24.	CORDIAL	swift	muddy	leafy	affable
25.	SQUANDER	tease	belittle	slice	waste
26.	SERRATED	dried	notched	armed	blunt
27.	PLAGIARIZE	maintain	intend	revoke	pilfer
28.	ORIFICE	brush	hole	building	lute
29.	PRISTINE	vain	sound	unspoiled	level
30.	INNOCUOUS	powerful	pure	medicinal	harmless
31.	JOCOSE	humorous	paltry	fervid	plain
32.	RUE	deal	lament	dominate	cure
33.	INEXORABLE	untidy	inviolable	relentless	sparse
34.	DIVEST	dispossess	intrude	rally	pledge
35.	MOLLIFY	mitigate	direct	pertain	abuse
36.	QUERULOUS	maniacal	curious	devout	complaining
37.	ABET	waken	ensue	incite	placate
38.	DESUETUDE	disuse	remonstrance	corruption	inanity
39.	PEREGRINATE	contemplate	mince	solidify	traverse
40.	QUOTIDIAN	travesty	everyday	calculation	promise

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