MCMI®-IV

MILLON® CLINICAL
MULTIAXIAL INVENTORY–IV

MCMI®-IV
Millon® Clinical Multiaxial Inventory-IV
Interpretive Report
Theodore Millon, PhD, DSc

Name:	Robert Sample
ID Number:	111222
Age:	33
Gender:	Male
Setting:	Outpatient never hospitalized
Education:	High school diploma or equivalent
Race:	White
Marital Status:	Never Married
Date Assessed:	10/13/2015

PsychCorp

[1.0 / RE1 / QG1]

REPORT SUMMARY

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

Interpretive Considerations

The patient is a 33-year-old single white male with a high school diploma or equivalent. He is currently being seen as an outpatient, and he reports that he has recently experienced a problem that involves his job or school. These self-reported difficulties, which have occurred for an unspecified period of time, may take the form of a clinical syndrome disorder.

Profile Severity

On the basis of the test data, it may be reasonable to assume that the patient is experiencing a moderately severe mental disorder; further professional study may be advisable to assess the need for ongoing clinical care. The text of the following interpretive report may need to be modulated only slightly upward or downward given this probable level of severity.

Possible Diagnoses

He appears to fit the following personality disorder classifications best: Antisocial Personality Disorder, with Unspecified Personality Disorder (Masochistic) Type, Avoidant Personality Type, and Borderline Personality Style.

Clinical syndromes are suggested by the patient's MCMI-IV profile in the areas of Alcohol Use Disorder and Other (or Unknown) Substance Use Disorder.

Therapeutic Considerations

Moody and unpredictable, this person may act in a self-demeaning yet angry way in anticipation of condemnation from others. Psychological difficulties may leave him feeling unduly vulnerable and contrary. Close attention and a supportive attitude should diminish noncompliance. Any sign of uncooperativeness should be responded to in a firm, no-nonsense manner that is professional rather than punitive in character. A brief and focused approach to therapy should be effective in moderating his erratic emotions and behavior.

MILLON CLINICAL MULTIAXIAL INVENTORY-IV

PROFILE SUMMARY

HIGH-POINT CODE = 6A 8B 2A
BR ADJUSTMENTS = None

INVALIDITY (V) = 0
INCONSISTENCY (W) = 6

VALIDITY		Score Raw	Score BR	Profile of BR Scores 0 35 75 100
Modifying Indices				Low Average High
Disclosure	X	51	73	
Desirability	Y	5	25	
Debasement	Z	7	53	

PERSONALITY		Score Raw	Score PR	Score BR	Profile of BR Scores 0 60 75 85 115
Clinical Personality Patterns					Style Type Disorder
Schizoid	1	11	70	69	
Avoidant	2A	14	81	79	
Melancholic	2B	9	53	65	
Dependent	3	6	50	60	
Histrionic	4A	8	33	43	
Turbulent	4B	10	47	60	
Narcissistic	5	9	74	69	
Antisocial	6A	16	98	90	
Sadistic	6B	7	67	65	
Compulsive	7	11	24	47	
Negativistic	8A	8	55	65	
Masochistic	8B	19	97	82	
Severe Personality Pathology					
Schizotypal	S	10	73	67	
Borderline	C	9	66	69	
Paranoid	P	6	61	64	

PSYCHOPATHOLOGY		Score Raw	Score PR	Score BR	Profile of BR Scores 0 60 75 85 115
Clinical Syndromes					Present Prominent
Generalized Anxiety	A	4	40	60	
Somatic Symptom	H	1	19	10	
Bipolar Spectrum	N	7	59	66	
Persistent Depression	D	7	41	47	
Alcohol Use	B	6	93	85	
Drug Use	T	8	85	77	
Post-Traumatic Stress	R	2	38	40	
Severe Clinical Syndromes					
Schizophrenic Spectrum	SS	7	50	60	
Major Depression	CC	1	21	12	
Delusional	PP	1	45	60	

MILLON CLINICAL MULTIAXIAL INVENTORY-IV

FACET SCALES FOR HIGHEST ELEVATED PERSONALITY SCALES

FACET SCALES		Score Raw	PR	BR	Profile of BR Scores 0 35 75 100
Antisocial	**6A**				Interpretable
Interpersonally Irresponsible	6A.1	2	48	60	
Autonomous Self-Image	6A.2	8	99	90	
Acting-Out Dynamics	6A.3	6	92	78	
Masochistic	**8B**				
Undeserving Self-Image	8B.1	7	79	72	
Inverted Architecture	8B.2	5	79	72	
Temperamentally Dysphoric	8B.3	5	55	65	
Avoidant	**2A**				
Interpersonally Aversive	2A.1	7	85	82	
Alienated Self-Image	2A.2	3	50	65	
Vexatious Content	2A.3	4	69	75	

GROSSMAN FACET SCALE SCORES

		Raw	PR	BR
1	**Schizoid**			
1.1	Interpersonally Unengaged	4	66	68
1.2	Meager Content	6	76	72
1.3	Temperamentally Apathetic	2	44	60
2A	**Avoidant**			
2A.1	Interpersonally Aversive	7	85	82
2A.2	Alienated Self-Image	3	50	65
2A.3	Vexatious Content	4	69	75
2B	**Melancholic**			
2B.1	Cognitively Fatalistic	3	39	60
2B.2	Worthless Self-Image	6	85	82
2B.3	Temperamentally Woeful	1	30	30
3	**Dependent**			
3.1	Expressively Puerile	4	59	65
3.2	Interpersonally Submissive	3	70	70
3.3	Inept Self-Image	2	38	60
4A	**Histrionic**			
4A.1	Expressively Dramatic	2	55	65
4A.2	Interpersonally Attention-Seeking	3	22	36
4A.3	Temperamentally Fickle	6	53	64
4B	**Turbulent**			
4B.1	Expressively Impetuous	3	48	60
4B.2	Interpersonally High-Spirited	2	22	30
4B.3	Exalted Self-Image	7	84	75
5	**Narcissistic**			
5.1	Interpersonally Exploitive	3	64	65
5.2	Cognitively Expansive	4	40	48
5.3	Admirable Self-Image	3	83	75
6A	**Antisocial**			
6A.1	Interpersonally Irresponsible	2	48	60
6A.2	Autonomous Self-Image	8	99	90
6A.3	Acting-Out Dynamics	6	92	78
6B	**Sadistic**			
6B.1	Expressively Precipitate	6	90	75
6B.2	Interpersonally Abrasive	3	72	68
6B.3	Eruptive Architecture	1	49	60
7	**Compulsive**			
7.1	Expressively Disciplined	3	28	45
7.2	Cognitively Constricted	7	66	68
7.3	Reliable Self-Image	2	3	20
8A	**Negativistic**			
8A.1	Expressively Embittered	3	64	70
8A.2	Discontented Self-Image	6	73	72
8A.3	Temperamentally Irritable	3	62	68
8B	**Masochistic**			
8B.1	Undeserving Self-Image	7	79	72
8B.2	Inverted Architecture	5	79	72
8B.3	Temperamentally Dysphoric	5	55	65
S	**Schizotypal**			
S.1	Cognitively Circumstantial	3	49	60
S.2	Estranged Self-Image	5	70	66
S.3	Chaotic Content	3	71	66
C	**Borderline**			
C.1	Uncertain Self-Image	0	14	0
C.2	Split Architecture	8	90	78
C.3	Temperamentally Labile	3	59	64
P	**Paranoid**			
P.1	Expressively Defensive	4	68	68
P.2	Cognitively Mistrustful	1	39	60
P.3	Projection Dynamics	4	81	75

RESPONSE TENDENCIES

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

The response style of this patient showed no unusual test-taking attitude that would distort MCMI-IV results.

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 clinical syndromes, this section concentrates on his more habitual and maladaptive methods of relating, behaving, thinking, and feeling.

The MCMI-IV profile of this man suggests that he may be characterized by unpredictable and depressive moods, edgy irritability, and feelings of being cheated, misunderstood, and unappreciated. An intense conflict may exist between his needs for dependency on the one hand and self-assertion on the other. This may contribute to creating an impulsive emotionality. Possibly critical and bitter, he may often feel like a victim, overburdened and mistreated. He may use guilt to undermine the anger of others, claiming that he has been misunderstood and unfairly accused. A pattern of pouting, self-pity, negativism, and pessimism may be present, possibly punctuated by occasional angry outbursts followed by expressions of guilt and contrition.

It is likely that this man permits himself to be exploited occasionally by engaging in self-sacrificing acts. He may anticipate being disillusioned; for this reason, he behaves obstructively, thereby creating confusion in others and producing the expected disappointment. His personal relationships are likely to be tenuous and turbulent, fraught with wrangles and antagonism that may be provoked by his complaining and passive-aggressive attitude. He may choose to relate to marginal acting-out types with whom he can suffer and identify. A struggle between feelings of suffering, dejection, and guilt may result in a rapid succession of moods. Unstable and erratic, he may be easily offended, contrary, and depressed by trifles. A low tolerance for frustration may be notable, as is vacillation between being distraught and being contentious. He may be stereotyped as a person who suffers and complains because of his own self-sabotaging and self-debasing. He may also be known as the one who dampens everyone's spirits: a somber, forlorn, irritable malcontent who demoralizes others and obstructs their pleasures.

There may be a struggle between acting out and curtailing his resentments. Vacillating between feeling cared for by others and then feeling discarded by them, he may exhibit sulking and moody behavior that induces others to react in a similarly inconsistent manner. As a consequence, he may feel bitter and unappreciated, and tends to be disconsolate, sensitive, and defensive.

GROSSMAN FACET SCALES

By examining the elevated Grossman Facet Scale scores for the Clinical Personality Patterns and Severe Personality Pathology scales, it is possible to identify a patient's most troublesome or clinically-significant functional and structural domains (e.g., self-image, interpersonal conduct). A careful analysis of this individual's facet scale scores suggests the following characteristics are among his most prominent personality features.

Most notable are an interpersonal style characterized by unreliable, untrustworthy, and potentially dishonest tendencies. Despite their consequences, he may intentionally or unintentionally ignore or negate personal obligations. He may actively intrude upon and violate the rights of others, and he may transgress established social codes by ways of deceitful or illegal behaviors. Moreover, he may find great pleasure in these intrusions and transgressions, as he may enjoy the act of usurping and taking from others.

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

Also worthy of attention is his failures to constrain or postpone the expression of offensive thoughts or malevolent actions, deficits in guilty feelings, and a consequent disinclination to refashion his repugnant impulses in sublimated form. Given his perception of the environment, he does not feel the need to rationalize his outbursts, which he believes are fully defensible as a response to the supposed malevolence of others. He experiences himself as a victim, an indignant bystander subjected to persecution and hostility. Through this intrapsychic maneuver, he not only disowns his malicious impulses but attributes the evil to others. Moreover, as the victim, he feels justified to counterattack and gain restitution and vindication.

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

CLINICAL SYNDROMES

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

Prompted largely by feelings of self-disillusionment and deep resentment toward others, recurrent periods of alcohol abuse appear to be a major problem for this man. Characteristically moody and impulsive, his behavior becomes intensified when he is drinking heavily. During these times, his chronic level of anger and irritability is likely to become greatly aggravated and may lead to irrational accusations, physical intimidation, and perhaps brutality toward others. Although he may subsequently express genuine feelings of guilt and contrition, the destructive and injurious effects of his behavior are likely to persist. In more sober periods, his drinking primarily serves to moderate the deep ambivalence he feels toward himself, his relationships with others, and his lot in life. Moreover, a strong self-destructive aspect of his drinking compels him to undermine both himself and others.

This man's MCMI-IV responses suggest that he either has abused or is currently abusing prescription medications, illicit drugs, or both. Irritable, negative, and hostile, he may use drugs not only to help him unwind his tensions and undo his conflicts, but also to serve as a statement of resentful independence from the constraints of social convention and expectation. In addition to liberating his feelings of ambivalence toward himself and others, drugs remove whatever remnants of guilt he may experience over discharging his less charitable impulses and fantasies. Defiant and resentful acts of hostility such as these may often have self-destructive undertones, which may be evident during periods of heavy use when he exhibits a careless indifference to the consequences of his behavior.

NOTEWORTHY RESPONSES

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

Interpersonally Alienated

4. Item Content Omitted (True)

Emotional Dyscontrol

27. Item Content Omitted (True)
36. Item Content Omitted (True)
56. Item Content Omitted (True)
177. Item Content Omitted (True)

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

Self-Destructive Potential

34. Item Content Omitted (True)
39. Item Content Omitted (True)
59. Item Content Omitted (True)
126. Item Content Omitted (True)
164. Item Content Omitted (True)

Childhood Abuse

157. Item Content Omitted (True)

Vengefully Prone

100. Item Content Omitted (True)
167. Item Content Omitted (True)
192. Item Content Omitted (True)

Explosively Angry

11. Item Content Omitted (True)
115. Item Content Omitted (True)
191. Item Content Omitted (True)

Autism Spectrum

119. Item Content Omitted (True)
138. Item Content Omitted (True)
165. Item Content Omitted (True)
179. Item Content Omitted (True)

POSSIBLE *DSM-5®* DIAGNOSES

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

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

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

305.00 (F10.10) Alcohol Use Disorder
305.90 (F19.10) Other (or Unknown) Substance Use Disorder

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

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

Personality configuration composed of the following:

301.7 (F60.2) Antisocial Personality Disorder
with Unspecified Personality Disorder (Masochistic) Type
Avoidant Personality Type
and Borderline Personality Style

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

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

Job or School Problems

TREATMENT GUIDE

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

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

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.

Inroads to treatment are expected to be difficult as this man is likely to have built interpersonal defenses that have successfully warded off anyone presumed to be threatening. The clinician is advised that initial sessions may be qualitatively tense, and may give the impression that volatility is inevitable and unavoidable. Awareness and patience are vital on the part of the therapist if this man is to feel comfortable enough to explore sensitive areas without contrariness or aggressiveness. In essence, this man's default interpersonal position is to actively guard and ward off in a variety of ways, and rapport building is dependent on respect of extant boundaries, even when rigid. Effectively managing flexible but adaptive self-boundaries and meeting this man's challenges with equanimity and willingness to explore immediate interaction may serve as a catalyst to a deeper therapeutic alliance in a more abbreviated amount of time.

Primary goals in focused treatment include facilitating autonomy, building confidence, and overcoming fears of self-determination, all guarded against by the foregoing interpersonal boundary. Because efforts to encourage him to assume responsibility and self-control may be perceived as a sign of criticism, abuse, or rejection, it is important to address these feelings. Thus, empathic, warm, and consistent trust-building are fundamental to preventing disappointment, dejection, and even rage. These potential reactions should be anticipated, given his characteristic style, and they must be countered in a calm and nuanced manner if fundamental changes are to be explored and relapses prevented. When a sound and secure therapeutic alliance has been established, he may then begin to learn to tolerate these contrary feelings and dependency anxieties. Experiencing and managing these unstable emotions must be coordinated with the strengthening of a balanced perspective, widening from cynicism and prejudgment to tolerance and humility. Interpersonal methods seeking to understand and modify contrary or irresponsible reactions will also help to bring about more comfortable social interactions. In this regard, the therapist may serve as a model to demonstrate how feelings, conflicts, and uncertainties can be approached and resolved with reasonable equanimity and foresight. Also worth exploring are group modalities or family involvement that may be used to test these newly learned attitudes and strategies in a more natural setting than that found in individual treatment.

As implied, this man may avoid confronting and resolving his real interpersonal difficulties by relying on an attitude of affective instability and self-deprecation. His coping maneuvers are a double-edged sword, however, relieving passing discomfort and strains but perpetuating faulty attitudes and strategies. Bringing attention to the true cost-benefit of these coping strategies becomes important in addressing expectations of debasement and/or inconsistency by others, and correcting the fallacy of attempting to control negative outcomes by perpetuating them.

Particular attention is necessary to anticipate and counteract the possibility that this man's hold on reality may disintegrate and his capacity to function may wither. Similar care should be taken when the attention and support that he requires are withdrawn or when his strategies prove wearisome and exasperating to others, possibly precipitating their anger. Pharmacologic agents should be considered if he begins to succumb to depression or to an erratic surge of hostility. At crucial times of greater distress, it may be necessary to anticipate and quell the danger of suicide or self-harm. A potential concern throughout treatment is the forestalling of a persistent decompensation process. Among the early signs of such a breakdown are marked discouragement and melancholic dejection. At this phase, supportive therapy is called for, and cognitive reorientation methods should be actively pursued. Efforts should be made to boost his sagging morale, to encourage him to continue in his usual sphere of activities, to build his self-confidence, and to deter him from being preoccupied with his melancholy feelings. He should not be pressed beyond his capabilities, however, for his failure to achieve goals will only strengthen his conviction of his incompetence and unworthiness. Properly-executed cognitive methods oriented to correcting erroneous assumptions and beliefs can be especially helpful.

End of Report

ITEM RESPONSES

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