Corrections Interpretive Report - Revised

MCMI®-III
Millon® Clinical Multiaxial Inventory-III
Theodore Millon, PhD, DSc

Name:	Sample One
ID Number:	1
Age:	35
Gender:	Male
Setting:	Correctional Inmate
Race:	White
Marital Status:	First Marriage
Date Assessed:	10/21/2014

SAMPLE

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[4.3 / RE1 / QG1]

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CLINICAL SUMMARY

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

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

Interpretive Considerations
The offender is a 35-year-old married white male with 12 years of education. He is currently being seen as a correctional offender, and he reports that he has recently experienced problems that involve antisocial behavior and marriage or family. These self-reported difficulties, which have occurred in the last three to 12 months, may take the form of an Axis I disorder.

Profile Severity
On the basis of MCMI-III test data, it may be inferred that the offender is experiencing a severe mental disorder; further professional observation and inpatient care may be appropriate. The text of the following interpretive report may need to be modulated upward given this probable level of severity. Empirical research indicates that this offender is likely to require mental health services.

Possible *DSM-IV*® Diagnoses
He appears to fit the following Axis II classifications best: Schizoid Personality Disorder, with Dependent Personality Traits, Avoidant Personality Traits, and Depressive Personality Features.

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

If Treatment Services are Recommended
This offender may have developed a pattern of relating to others in a retiring, listless, and dejected manner. A poor reporter of his personal history and increasingly withdrawn from his problems, he may be difficult to engage in therapeutic intervention. Enlisting the aid of family members and focusing on short-term cognitive techniques may be useful in maximizing compliance and achieving a measure of progress.

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MILLON CLINICAL MULTIAXIAL INVENTORY - III

CONFIDENTIAL INFORMATION FOR PROFESSIONAL USE ONLY

VALIDITY (SCALE V) SCORE = 0
PERSONALITY CODE: 1 ** 3 2A * 2B + 7 5 8B 4 " 8A 6B 6A ' ' // - ** - * //
SYNDROME CODE: - ** A D * // - ** CC * //
DEMOGRAPHIC CODE: 1/CI/M/35/W/F/12/AN/MA/------/4/------/

CATEGORY		RAW	BR	PROFILE OF BR SCORES (0 / 60 / 75 / 85 / 115)	DIAGNOSTIC SCALES
MODIFYING INDICES	X	83	53		DISCLOSURE
	Y	12	55		DESIRABILITY
	Z	14	69		DEBASEMENT
CLINICAL PERSONALITY PATTERNS	1	15	85		SCHIZOID
	2A	7	79		AVOIDANT
	2B	7	73		DEPRESSIVE
	3	12	82		DEPENDENT
	4	9	36		HISTRIONIC
	5	9	42		NARCISSISTIC
	6A	0	0		ANTISOCIAL
	6B	2	17		SADISTIC
	7	20	58		COMPULSIVE
	8A	3	22		NEGATIVISTIC
	8B	2	38		MASOCHISTIC
SEVERE PERSONALITY PATHOLOGY	S	1	19		SCHIZOTYPAL
	C	8	63		BORDERLINE
	P	5	60		PARANOID
CLINICAL SYNDROMES	A	7	82		ANXIETY
	H	10	72		SOMATOFORM
	N	0	0		BIPOLAR: MANIC
	D	13	82		DYSTHYMIA
	B	3	45		ALCOHOL DEPENDENCE
	T	0	0		DRUG DEPENDENCE
	R	11	72		POST-TRAUMATIC STRESS
SEVERE CLINICAL SYNDROMES	SS	8	65		THOUGHT DISORDER
	CC	15	78		MAJOR DEPRESSION
	PP	1	25		DELUSIONAL DISORDER

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

CORRECTIONAL SUMMARY

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

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

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

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Reaction to Authority
This offender is apt to be socially isolated, anxious, and dependent. He is not inclined to be troublesome, and is rather quiet, submissive, generally ineffectual, and withdrawn.

Escape Risk
Even if opportunities arise, this offender is not likely to engage in escape behavior.

Disposition to Malinger
This offender's characteristic withdrawal and worrisomeness may resemble malingering but actually represent a pattern of ineffectuality that is not consciously intended.

Response to Crowding/Isolation
Placement of this offender in a "safe" living unit would be wise, in part to reduce discomfiting social pressures and in part to decrease the likelihood of his being preyed upon and humiliated.

Amenability to Treatment/Rehabilitation
It may be necessary to prevent this prisoner from withdrawing into self-imposed isolation. Educational rehabilitation may be advisable to compensate for a limited school or work background. The program should be sufficient to ensure at least a modicum of marketable post-release skills. His receptivity to such efforts, however, may prove to be slow and arduous.

Suicidal Tendencies
As indicated above, the research-based, multi-scale MCMI-III prediction model classifies this offender as having a high probable need for mental health intervention. In addition, his item responses indicate that he has recently thought about committing suicide.

RESPONSE TENDENCIES

The BR scores reported for this individual have been modified to account for the psychic tension and dejection indicated by the elevations on Scale A (Anxiety) and Scale D (Dysthymia).

AXIS II: PERSONALITY PATTERNS

The following paragraphs refer to those enduring and pervasive personality traits that underlie this 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.

MCMI-III profiles such as this man's signify tendencies to be introversive, emotionally impoverished, and expressively either impassive or depressed. Preferring to remain in the background, he may lack social initiative and display little stimulus-seeking behavior. Notable also are cognitive deficits and unclear thinking about interpersonal matters. Anger and discontent rarely surface. More typically, he will appear sad or disengaged emotionally. Reluctant to accept help from others, he is likely to sacrifice his own interests, try not to be a burden to others, and act in a compliant and placating manner. His easy fatigability and slow personal tempo may be compounded by a general weakness in expressiveness and spontaneity. Although he is prone to assume a peripheral role in social and family relationships, he may also have a need to gain some measure of support from significant others. These conflicting attitudes stem in part from his feelings of low self-esteem and his deficiencies in autonomous and competent behavior. Quick to self-blame, he is inclined to belittle himself and to possess a self-image of being a weak and ineffectual person.

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Daily life for this offender may be experienced as uneventful, with extended periods of passive solitude interspersed with feelings of sadness and emptiness. He is likely to have endorsed items such as "Few things in life give me pleasure." He tries to be indifferent to his social surroundings, is minimally introspective, and is sufficiently withdrawn as to miss the subtleties of emotional life, and he exhibits few affectionate or erotic needs. His thought processes tend to be unfocused and tangential, particularly in regard to interpersonal matters. As a result, his social communications are often strained and self-conscious. His hesitation to express affection may stem from an inability to experience enthusiasm or pleasure. Moreover, for extended periods, he may exhibit a pervasive dysthymic mood that is punctuated occasionally by unanchored and ill-defined anxiety.

This man prefers to follow a simple, repetitive, and dependent life pattern. He actively avoids self-assertion, appears spiritless and cheerless, abdicates autonomous responsibilities, and may be indifferent to conventional social aspirations. Disengaged from and uninterested in most of the rewards of human affairs, he often appears apathetic, if not depressed and morose. Although lacking in drive, he is also fearful of rebuff. Therefore, he restricts his social and emotional involvements, which consequently perpetuates his pattern of social isolation and sadness.

AXIS I: CLINICAL SYNDROMES

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

Preoccupation with matters of personal adequacy and chronic feelings of worthlessness and guilt appear to predominate in the major depression evident in the clinical picture of this socially awkward and introverted man. Timid, shy, and apprehensive, he is especially sensitive to public humiliation and rejection. Worthy of note is his tolerance of daily unhappiness and emptiness, a willingness to accept his feelings of worthlessness and guilt. Plagued with self-doubts and thoughts of death, he may be notably saddened by the view that he is both socially unattractive and physically inferior. Fearful of expressing his discontent to others who might thereby reject or humiliate him, he deals with his frustration by turning it inward, becoming intropunitively depressed. This offender's score on MCMI-III Scale CC (Major Depression) is 78. Empirical research has shown that offenders scoring 75 or higher on Scale CC at intake are very much more likely to require prison-provided mental health services compared to offenders scoring below 75. This research is described in the *MCMI-III Corrections Report User's Guide*.

This man may be experiencing an anxiety disorder, noted by symptoms such as fatigue, insomnia, muscular tension, distracted thinking, and a general dysphoric mood. Basically shy and socially uncomfortable, he may be plagued by self-doubt. Especially hypersensitive to public humiliation or reproval, he may lack sufficient self-esteem to respond to such events by expressing the anger and resentment he might feel. His anxiety not only may be one of his general states--an omnipresent level of discomfort, especially with others--but also may be intensified by fear that his restrained anger may spew forth against persons he dares not provoke. This offender's score on MCMI-III Scale A (Anxiety) is 82. Empirical research has shown that offenders scoring 75 or higher on Scale A at intake are more likely to require prison-provided mental health services compared to offenders scoring below 75. This research is described in the *MCMI-III Corrections Report User's Guide*.

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NOTEWORTHY RESPONSES

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

Health Preoccupation

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

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

Interpersonal Alienation
10. Item Content Omitted (True)
27. Item Content Omitted (True)
92. Item Content Omitted (True)
105. Item Content Omitted (True)
167. Item Content Omitted (True)

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

Emotional Dyscontrol
34. Item Content Omitted (True)

Self-Destructive Potential
44. Item Content Omitted (True)
142. Item Content Omitted (True)
171. Item Content Omitted (True)

Childhood Abuse
No items endorsed.

Eating Disorder
No items endorsed.

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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 test 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 test. Definitive diagnoses must draw on biographical, observational, and interview data in addition to self-report inventories such as the MCMI-III test.

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

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

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

Personality configuration composed of the following:

301.20 Schizoid Personality Disorder
with Dependent Personality Traits
Avoidant Personality Traits
and Depressive Personality Features

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

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

Axis IV: Psychosocial and Environmental Problems
In completing the MCMI-III test, 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 individual. This information should be viewed as a guide for further investigation by the clinician.

Antisocial Behavior; Marriage or Family Problems

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TREATMENT GUIDE

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

As a first step, it would appear advisable to implement methods to ameliorate this offender's current state of clinical anxiety, depressive hopelessness, somatic or stress difficulties, as well as pathological personality functioning by the rapid implementation of supportive psychotherapeutic measures. With appropriate consultation, targeted psychopharmacologic medications may also be useful at this initial stage.

Once this offender's more pressing or acute difficulties are adequately stabilized, attention should be directed toward goals that would aid in preventing a recurrence of problems, focusing on circumscribed issues and employing delimited methods such as those discussed in the following paragraphs.

A major thrust of brief therapy for this offender should be to enhance his social interest and competence. Although he should not be pushed beyond tolerable limits, careful and well-reasoned cognitive methods (e.g., Beck, Meichenbaum) may foster the development of more accurate and focused styles of thinking. In addition to working toward the extinction of false beliefs about himself and the attitudes of others toward him, the therapist should be alert to spheres of life in which the offender possesses positive emotional inclinations and should encourage the offender, through interpersonal methods and behavior skill development techniques, to undertake activities consonant with these

tendencies.

Although the success of short-term methods may justify an optimistic outlook, the offender's initial receptivity may create the misleading perception that further advances and progress will be rapid. Care should be taken to prevent early treatment success from precipitating a resurfacing of his established ambivalence between wanting social acceptance and fearing that he is placing himself in a vulnerable position. Enabling him to forgo his long-standing expectations of disappointment may require "booster" sessions following initial, short-term success. Support should be provided to ease his fears, particularly his feeling that his efforts may not be sustainable and will inevitably result in social disapproval again.

With appropriate consultation, psychopharmacologic treatment may be considered. Trial periods with a number of agents may be explored to determine whether any effectively increase his energy and affectivity. Such agents should be used with caution, however, because they may activate feelings that the offender is ill-equipped to handle. As noted, attempts to cognitively reorient his problematic attitudes may be useful in motivating interpersonal sensitivity and confidence. Likewise, short-term techniques of behavioral modification may be valuable in strengthening the offender's social skills. Group and family methods may be useful in encouraging and facilitating his acquisition of constructive social attitudes. In these benign settings, he may begin to alter his social image and develop both the motivation and the skills for a more effective interpersonal style. Preceding or combining short-term programs with individual treatment sessions may aid in forestalling untoward recurrences of the discomfort currently experienced by the offender.

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Focused treatment efforts for this introversive and passive man are best directed toward countering his withdrawal tendencies. Minimally introspective and evincing diminished affect and energy, he must be prevented, through circumscribed therapies, from becoming increasingly isolated from others, be they discomforting or benign. Energy should be invested to enlarge his social world owing to his tendencies to pursue with diligence only those activities required by his job or by his family obligations. By shrinking his interpersonal milieu, he precludes exposure to new experience. Of course, this is his preference, but such behavior only fosters his isolated and withdrawn existence. To prevent such backsliding and a relapse, the therapist should ensure the continuation of all constructive social activities as well as potential new ones. Otherwise, he may become increasingly lost in asocial and fantasy preoccupations. Excessive social pressure, however, should be avoided because the offender's tolerance and competencies in this area are likely to be limited. Initial brief and focused treatment techniques will aid him in developing more skills in this area.

End of Report

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

ITEM RESPONSES

1: 1 2: 1 3: 2 4: 1 5: 2 6: 2 7: 2 8: 2 9: 2 10: 1
11: 2 12: 2 13: 2 14: 2 15: 2 16: 1 17: 2 18: 2 19: 2 20: 2
21: 2 22: 2 23: 1 24: 2 25: 2 26: 1 27: 1 28: 2 29: 1 30: 2
31: 2 32: 2 33: 2 34: 1 35: 2 36: 2 37: 2 38: 2 39: 2 40: 1
41: 2 42: 2 43: 2 44: 1 45: 2 46: 2 47: 1 48: 2 49: 2 50: 2
51: 2 52: 2 53: 2 54: 2 55: 1 56: 1 57: 2 58: 2 59: 1 60: 1
61: 2 62: 1 63: 2 64: 1 65: 2 66: 2 67: 2 68: 1 69: 2 70: 2
71: 2 72: 1 73: 2 74: 1 75: 2 76: 2 77: 2 78: 2 79: 2 80: 1
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171: 1 172: 1 173: 2 174: 2 175: 1

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