New Directions in Interpreting the Millon™ Clinical Multiaxial Inventory-III (MCMI-III™)

Edited by
Robert J. Craig
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Contents

Contributors vii
Introduction ix

Part I New Directions in MCMI Interpretation

1 The MCMI-III™ Facet Subscales
   Seth D. Grossman and Cristian del Rio 3

2 Diagnosing Personality Disorder Subtypes with
   the MCMI-III™
   Roger D. Davis and Michael J. Patterson 32

3 Alternative Interpretations for the Histrionic, Narcissistic,
   and Compulsive Personality Disorder Scales of the MCMI-III™
   Robert J. Craig 71

4 Combined Use of the PACL and MCMI-III™ to Assess
   Normal Range Personality Styles
   Stephen Strack 94

5 Issues in the Assessment of Personality Disorders and
   Substance Abusers with the MCMI
   Patrick M. Flynn 129

6 International Uses of the MCMI: Does Interpretation Change?
   Gina Rossi and Hedwig Sloore 144

Part II Newer Applications with the MCMI-III™

7 Using the MCMI-III™ for Treatment Planning and to Enhance
   Clinical Efficacy
   Jeffrey J. Magnavita 165

8 Use of the MCMI-III™ with Other Personality Inventories
   Robert J. Craig 185
vi CONTENTS

9 Forensic Application of the MCMI-III™ in Light of Current Controversies

Frank J. Dyer

201

Part III Continuing Controversies

10 Assessing Response Bias with the MCMI Modifying Indices
R. Michael Bagby and Margarita B. Marshall

227

11 Validity of the MCMI-III™ in the Description and Diagnosis of Psychopathology
Andrew G. Ryder and Scott Wetzler

248

12 The Diagnostic Efficiency of the MCMI-III™ in the Detection of Axis I Disorders
Paul Gibeau and James Choca

272

13 On the Decline of MCMI-Based Research
Robert J. Craig and Ronald E. Olson

284

14 Using Critiques of the MCMI to Improve MCMI Research and Interpretations
Louis Hsu

290

Appendix A: Diagnoses Associated with MCMI Code Types

321

Appendix B: Millon Clinical Multiaxial Inventory Bibliography

357

About the Editor

403

Author Index

405

Subject Index

413
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Introduction

The Millon™ Clinical Multiaxial Inventory (as revised)–III™ (MCMI-III™) has become a mainstay in clinical assessment and is used in a multiplicity of settings and for a variety of assessment and treatment planning purposes. Research cited throughout this book documents its frequent use in clinical, counseling, medical, and forensic services in both public and private practice venues. Only the MMPI and the Rorschach have enjoyed such widespread application.

Clinicians value this test because of its clinical utility. And yet, science does not stand still. New discoveries, new conceptualizations, new research, and critical analysis continue to refine the way we assess and the way we frame these assessments. The same is true for personality assessment in general and for the MCMI-III in particular. Millon continues to refine his bioevolutionary model, on which the test is based, and his prototype personality disorders have evolved toward greater specificity with the theorized personality disorder subtypes. With the introduction of the third edition of the MCMI, researchers are determining how well this latest revision compares with its MCMI predecessors, as well as evaluating the test in light of some continuing controversies. Much of this new way of thinking about and understanding the MCMI are presented in this book. Contemporary research issues relating to the MCMI are also discussed.

This book is divided into three main sections. Part I addresses some new directions in interpreting the MCMI. Part II highlights some newer applications of the MCMI-III. Finally, Part III addresses some of the continuing controversies with the MCMI-III. The critical analyses on which these chapters are based actually appeared in relation to the MCMI-I and -II, and it remains to be seen whether or not these criticisms will remain applicable to the MCMI-III.

The MCMI is a theory-derived instrument for measuring Millon’s taxonomy of personality classification. He initially used a biopsychosocial model for his theoretical notions, but this was eventually superseded by a bioevolutionary model that generated, from theory, basic personality styles for nonclinical populations as well as personality disorders that were consistent with but not isomorphic with diagnostic classification.
systems (i.e., DSM, ICD). He also invoked a domain model, consisting of structural and functional criteria, with which to characterize and describe each of the personality disorders in his classification system. The MCMI was designed to assess whether or not a given patient had the traits, characteristics, and behaviors associated with a given disorder at the diagnostic level. If so, the psychologist could use Millon’s domain model to describe the prototypical patient with this disorder.

Millon was quite insistent in arguing that (1) there are no pure cases; (2) few, if any, patients would have every essential detail contained in the prototype characterization; and (3) real-world personalities would appear as variants and admixtures of the basic type. His next step was to suggest some basic subtypes or variants around the main type. Each subtype would have the essential features that define the disorder but would also have salient traits and behaviors that give a unique color or shading to this basic type. For example, although all patients with a Borderline Personality Disorder have common features, a borderline with dependent features appears quite different from a borderline with antisocial features. Millon suggested that each prototype has four or five subtypes (maybe more) and devised MCMI code types to reflect these variations.

In Chapter 1 ("The MCMI-III Facet Subscales"), Grossman and del Rio discuss the development of new content scales for the MCMI-III. The development of additional scales after a test has been published is not a new idea. The MMPI began with a basic set of validity and clinical scales but has evolved to the point where there are now more special scales for the MMPI than there are individual items (Dahlstrom, Welsh, & Dahlstrom, 1979). Gough’s Adjective Check List (Gough & Heilbrun, 1983) began as a test with validity and basic need scales and has evolved to include more than a score of topical (i.e., special) scales. The same can be said for the Rorschach, 16 Personality Factor Test, and the California Psychological Inventory, Revised.

The MCMI has also seen the development of special content scales from the basic test. Retzlaff (1993) developed special scales for the MCMI-I, but his efforts were an attempt to “purify” the MCMI with psychometric and statistical applications to the MCMI item pool. In contrast, Grossman and del Rio have developed facet subscales to the basic MCMI-III Personality Disorder scales. These were anchored to Millon’s bioevolutionary theory and began with a rational review of the test’s basic scales and their structural and functional domains. Their chapter reviews the development of these facet subscales for each of the MCMI-III Personality Disorder parent scales and demonstrates their utility for personality assessment, treatment planning, and intervention.
In Chapter 2 ("Diagnosing Personality Disorder Subtypes with the MCMI-III"), Davis and Patterson begin by referencing some of the problems inherent in the assessment of personality disorders. These include the currently high comorbidity among personality disorder diagnoses based on current criteria sets, the lack of complete agreement among personality theorists as to the exact number of personality disorder diagnoses that should be referenced in official diagnostic nomenclature, and multiple theories of personality, each deriving a different set of personality construct measurements. Millon’s theory, they argue, fixes the actual number of personality disorders that exist in nature, though Millon and Davis (1996), in an earlier publication, developed an initial list of possible personality disorder subtypes that may exist but that are not fixed in nature. These personality disorder subtypes are presented in Davis and Patterson’s chapter, along with the interpretive logic to assess them with the MCMI-III. Finally, they discuss how Millon’s theoretical model could be used, with some modification, to explain the derivation of the personality disorder subtypes themselves.

In Chapter 3 ("Alternative Interpretations for the Histrionic, Narcissistic, and Compulsive Personality Disorder Scales of the MCMI-III"), Craig marshals empirical research over the past 20 years that suggests that the MCMI Compulsive scale is measuring a compulsive style and not a Compulsive Personality Disorder, and the MCMI Histrionic and Narcissistic scales each may be measuring a style or a disorder. He offers interpretive guidelines and descriptors when the test is measuring either the style or the disorder.

In Chapter 4 ("Combined Use of the PACL and MCMI-III to Assess Normal Range Personality Styles"), Strack discusses the developmental history of both the MCMI and the Personality Adjective Checklist, a test designed to assess Millon’s hypothesized personality styles in nonclinical populations using adjectives rather than questionnaire methodology. He then demonstrates how these two tests can be used in combination to refine personality assessments in nonclinical populations. Two case histories are provided as examples of this process. Strack’s methodology provides the clinician with a way to use the MCMI in settings where the likelihood of the manifestation of a personality disorder is low, yet the strengths of the MCMI can be applied in a nontraditional manner.

When assessing substance abusers, clinicians have to consider issues that often are not present when assessing other populations. How much does substance abuse affect the test results? Is the resulting profile a manifestation of the person’s personality, or is it a drug-induced characterization? Can we assess someone while in detoxification, or should we wait until the detoxification has been completed? How long should we
wait before beginning the assessment? Testing clients early in treatment might capture their personality but could interact with withdrawal states, and testing clients later in treatment could interact with possible treatment effects. In Chapter 5 (“Issues in the Assessment of Personality Disorders and Substance Abusers with the MCMI”), Flynn highlights five key issues in assessing this population with the MCMI.

Most experts on personality agree with the experts on culture who argue that our personality tests were developed from a Eurocentric, Western frame of reference. All major (objective, self-report) personality tests have been translated into other languages, yet this, in itself, does not resolve the question of whether or not the test can be validly applied outside the culture on which the test was based. Although such understandings certainly apply to the MCMI, this test has an additional complication. Because personality disorders are not normally distributed in the general population, Millon persuasively argued that it is inappropriate to use normal scale distributions (such as T-Scores, or standard scores) with which to transform raw scores. Instead, he developed a base rate distribution and a base rate (BR) score. This distribution is based on that point in the distribution of scores where the patient has all the defining features of the disorder at the diagnostic level. BR scores are also dependent on the prevalence rate of the disorder within the standardization sample. This means that, in atypical settings, where the prevalence rate of a disorder is different from that observed in the standardization sample, the resulting BR score could be inaccurate. This is not much of a problem in the United States, but what about cross-culturally?

It is well known that culture does play a role in the manifestation of psychopathology. The *DSM-IV* Appendix B lists many culture-bound syndromes typically not found in Western culture. Most of the empirical research on psychological tests has focused on race, exploring possible differences in test scores among African Americans, Hispanics, and Caucasians, and debating whether any differences are manifestations of actual psychopathology or merely evidence of test bias against a given group. Rarely is the variable of *culture* considered apart from race, except at a theoretical level. I have not found any empirical study demonstrating that culture affects test scores.

In Chapter 6 (“International Uses of the MCMI: Does Interpretation Change?”), Rossi and Sloore, working in Belgium, look at the issue of culture and its effects on MCMI-III interpretation. (The MCMI is also in frequent use in the Scandinavian countries.) They discuss how culture can influence psychopathology and personality taxonomies. They argue that it cannot be presumed that the base rates of different syndromes and disorders are equivalent in different cultures or countries, even though U.S.-
developed personality instruments are in frequent use across Europe. In this chapter, Sloore and Rossi take up the question of whether BR scores from the MCMI-III manual are interpretively applicable in Belgium. Remember that the BR score is based, in part, on the prevalence rate of the disorder in the standardization sample. To the extent that prevalence rates of these disorders may differ, say, in Europe, this may result in diagnostic error unless the BR score itself is adjusted for those differences in prevalence rates. Using a large sample size of 524 patients, the authors compared the diagnostic efficiency of using base rates compared to receiver operating characteristics (ROC) for a Belgian sample. They compared sensitivity and specificity levels between both methodologies. They conclude that BR scores, derived from the ROC approach, performed better than BR scores based on prevalence rates. Their data are provocative, but one cannot argue with their conclusion: When using a diagnostic test, clinicians should have all possible diagnostic validity statistics available to them.

In an address to the Society for Personality Assessment, which was later published in the *Journal of Personality Assessment* (2002), Millon titled his talk (and, later, his publication) “Assessment Is Not Enough.” He argued that personality-guided assessment should lead to personality-guided therapy and offered some ideas as to how this can be accomplished. These ideas were later expanded in his book on therapy (Millon, Grossman, Meagher, Millon, & Everly, 1999). In Chapter 7 (“Using the MCMI-III for Treatment Planning and to Enhance Clinical Efficacy”), Magnavita discusses the utility of the MCMI-III in a variety of practice settings (psychiatric and medical hospital practice, community mental health centers, private practice, forensic settings) and stresses the importance of accurate clinical assessment for treatment planning. He introduces the concept of treatment packages, an individualized, comprehensive, and holistic approach to intervention that has targeted assessments at its base. He relies on Millon’s theoretical formulations as a foundation for assessment, understanding, and strategizing interventions. He provides a case example of marital dysfunction with spousal abuse to illustrate his seminal approach.

The MCMI-III can be used as a stand-alone test or as part of a psychological test battery. Many psychologists prefer to evaluate clients with a test battery because of issues that could result in convergent validity. That is, to the extent that the same psychological issues appear in more than one test, those issues are likely to be salient for a given respondent. Historically, psychologists have been trained to use a battery of both objective and projective tests in their clinical assessment. Examples of this abound in books and journals, but there have been few reports on using