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[14122171]

Millon Clinical Multiaxial Inventory-III [Manual Second Edition].

Purpose: Designed to provide diagnostic and treatment information to clinicians in the areas of personality disorders and clinical syndromes.

Population: "Adults [18+] who are seeking [or in] mental health treatment and who have eighth-grade reading skills."

Publication Dates: 1976-1997.

Acronym: MCMI-III.

Scores, 28: Modifying Indices (Disclosure, Desirability, Debasement, Validity), Clinical Personality Patterns (Schizoid, Avoidant, Depressive, Dependent, Histrionic, Narcissistic, Antisocial, Aggressive (Sadistic), Compulsive, Passive-Aggressive (Negativistic), Self-Defeating), Severe Personality Pathology (Schizotypal, Borderline, Paranoid), Clinical Syndromes (Anxiety, Somatoform, Bipolar: Manic, Dysthymia, Alcohol Dependence, Drug Dependence, Post-Traumatic Stress Disorder), Severe Clinical Syndromes (Thought Disorder, Major Depression, Delusional Disorder).

Administration: Individual or group.

Price Data, 2001: \$121.75 per preview package (specify mail-in or Microtest Q); \$302 per handscoring starter kit including manual (1997, 216 pages), handscoring user's guide (1994, 9 pages), 10 test booklets, 50 answer sheets, 50 worksheets, 50 profile forms, and answer keys; \$34 per prepaid interpretive mail-in answer sheet (specify English or Hispanic); \$35.45 per prepaid corrections interpretive mail-in answer sheet (specify English or Hispanic); \$17 per prepaid profile mail-in answer sheet (specify English or Hispanic); \$18.50 per 25 Microtest Q answer sheets (specify English or Hispanic); \$32 per interpretive Microtest Q report; \$33.45 per corrections interpretive Microtest Q report; \$15 per profile Microtest Q report; \$27 per 10 handscoring test booklets; \$45 per manual; \$17.50 per Corrections Report User's Guide (1998, 56 pages); \$65 per audiocassette (specify English or Hispanic).

Time: [25] minutes.

Comments: Designed to coordinate with DSM-IV categories of clinical syndromes and personality disorders; revision of the Millon Clinical Multiaxial Inventory-III (13:201); includes optional Corrections Report for use with correctional inmates.

Authors: Theodore Millon, Roger Davis, and Carrie Millon.

Publisher: NCS (Minnetonka).

Cross References: See T5:1687 (47 references); for reviews by Allen K. Hess and Paul Retzlaff of the third edition, see 13:201 (81 references); see T4:1635 (104 references); for reviews by Thomas M. Haladyna and Cecil K. Reynolds of the second edition, see 11:239 (74 references); for reviews by Allen K. Hess and Thomas A. Widiger of the original edition, see 9:709 (1 reference); see also T3:1488 (3 references).

Review of the Millon Clinical Multiaxial Inventory--III [Manual Second Edition] by JAMES P. CHOCA, Director of Doctoral Studies, School of Psychology, Roosevelt University, Chicago, IL:

During a discussion at the convention of the American Psychological Association (APA), Raymond Fowler, APA Executive Director, lamented that the most commonly used psychological tests today are the same as those that were most popular 50 years ago (Fowler, 1999). It would appear that the field has not been able to duplicate, during the second half of the 20th century, the creativity of the first 50 years. The Stanford-Binet, the Rorschach, the Thematic Apperception Test (TAT), the Minnesota Multiphasic Personality Inventory (MMPI), the Wechsler batteries, and the Halstead-Reitan Neuropsychological Test Battery all originated during that time. Of course, there have been new editions, scoring systems, and refinements for many of the important tools of our trade. There has been an explosion of literature and several new journals dedicated exclusively to testing. There have even been a myriad of minor instruments added to our repertoire. These accomplishments, however, seem modest in comparison to the accomplishments of the first half of the century.

Perhaps the most notable exception to this trend has been the Millon Clinical Multiaxial Inventory (MCMI; Millon, 1977, 1982, 1994). In spite of its relatively brief history, this instrument has become a commonly used clinical tool (Piotrowski & Keller, 1989; Piotrowski & Lubin, 1990; Watkins, Campbell, Nieberding, & Hallmark, 1995). Three books have been entirely dedicated to the MCMI (Choca & Van Denburg, 1997; Craig, 1993a, 1993b), and the test has been repeatedly included in textbooks dealing with psychological assessment (e.g., Beutler & Berren, 1995; Craig, 1999a; Groth-Marnat, 1997; Koocher, Norcross, & Hill, 1998; Maruish, 1994; McCann & Dyer, 1996; Millon, 1997a; Newmark, 1996; Strack, 1999). More than 500 published studies have used the MCMI to collect data (Craig, 1999b); in fact, only two personality tests (the MMPI and the Rorschach) have been the subject of more published studies than the MCMI in the recent past (Butcher & Rouse, 1996; Ritzler, 1996). Numerous reviews and critiques are available (Dana & Cantrell, 1988; Greer, 1984; Haladyna, 1992; Hess, 1985; Lanyon, 1984; McCabe, 1984; Reynolds, 1992; Wetzler, 1990; Wetzler & Marlowe, 1992; Widiger, 1985). The test is being used in other countries and has been translated into several other languages (Jackson, Rudd, Gazis, & Edwards, 1991; Luteijn, 1990; Montag & Comrey, 1987; Mortensen & Simonsen, 1990; Simonsen & Mortensen, 1990).

The MCMI has many advantages over its main competitor, the MMPI-2. For one thing, the instrument was especially designed to measure personality traits; although an assessment of the personality make-up can also be obtained from the MMPI-2, this reviewer believes that the MCMI offers a clearer and more comprehensive evaluation of the personality dimensions. In spite of being much shorter, the MCMI is just as valid and reliable as the MMPI-2. The instrument was normed with psychiatric patients and uses a new weighted score, the Base Rate Score (BRS), that takes into account the prevalence of the specific

disorder in the psychiatric population. Finally, Millon has been eager to adjust the inventory in order to incorporate theoretical developments, as well as changes in the classification system for mental disorders. In contrast, the basic clinical scales of the MMPI were not changed appreciably during the recent revision, and are still tied to a diagnostic system that is now archaic. Recent developments linking the theory into systems of treatment planning and psychotherapy (Choca & Van Denburg, 1997; Hyer, 1994; Retzlaff, 1995; Millon, 1999) make the test useful in situations where the interest is more therapeutic than diagnostic.

Compared with other instruments designed to measure personality traits (e.g., the NEO Personality Inventory, Costa & McCrae, 1985), the MCMI is a clinical inventory. It conceptualizes personality in the way clinicians think, using prototypes that have been part of the clinical literature for years. Because it also offers scales measuring clinical syndromes (Axis I of the DSM-IV), the diagnostician does not have to resort to a different instrument in order to assess those areas of functioning.

The MCMI is routinely used by itself as a screening instrument or as part of a test battery. When used as part of a battery, the referral question and history are typically considered in order to determine what other tests should be included. A typical battery to evaluate emotional problems may include more specialized self-report questionnaires (e.g., the Eating Disorders Inventory) and projective tests such as the Rorschach and the TAT. The MCMI has also been used as part of a neuropsychological battery to evaluate brain dysfunction.

As is often the case, some of the disadvantages of the MCMI are the direct result of advantages listed above. The fact that it is based on Millon's theory has limited, in the past, the degree of compatibility equivalent scales have had with the DSM disorders (Widiger & Sanderson, 1987; Widiger, Williams, Spitzer, & Frances, 1985). The current version (MCMI-III) has three personality scales that do not have a DSM-IV equivalent. Moreover, the efforts to make the test more DSM compatible may be limiting its compatibility with Millon's theory (Widiger, 1999). In his eagerness to move the MCMI along, Millon has already produced three editions of this test. The end result is that, in spite of the wealth of literature available on the original MCMI and the MCMI-II, clinicians using the current version will not have access to much empirical data for a few years to come. Given the drastic changes that were made (95 of the 175 items of the MCMI-II were replaced to create the MCMI-III), one can not assume that anything that was true of an earlier version remains true with the current version.

The scoring used for the MCMI-III has been criticized for being unduly complex in ways that do not improve the performance of the test (Retzlaff, 1991; Retzlaff, Sheehand, & Lorr, 1990; Streiner, Goldberg, & Miller, 1993; Streiner & Miller, 1989). The test derives 24 scales from 175 items or the equivalent of about 7 items per scale. It accomplishes this feat by having items load on more than one scale, but that causes psychometric problems and leads to some scales that are excessively intercorrelated.

In pushing the psychological testing envelope, Millon accepted the notion of publishing operating characteristics, or the number of examinees that the test correctly diagnoses. This idea was originally proposed by Gibertini, Brandenburg, and Retzlaff (1986) for the MCMI, and the operating characteristics of the first two editions spoke well for those instruments. In contrast, the operating characteristics for the MCMI-III left something to

be desired (Millon, 1994; Retzlaff, 1996). A second study was done by Roger Davis in an attempt to correct the problem, but the research design allowed clinicians who had seen the MCMI-III results to assign the diagnoses, obviously contaminating the data (study described in Millon, 1997b). It should be noted that having reasonable operating characteristics represents a very high standard for our current level of development. Even the most valid tests in our repertoire, such as the Wechsler Adult Intelligence Scale (WAIS-III), would probably fare poorly if we were to demand that--in the absence of any other information--the test results lead to an accurate DSM-IV diagnosis.

SUMMARY. In closing, it should be noted that some of the most arduous critics of the MCMI have continued to use this instrument in preference of anything else. As implied above, this reviewer sees this test as one of the greatest contributions made to the field during his professional life.

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Review of the Millon Clinical Multiaxial Inventory--III [Manual Second Edition] by THOMAS A. WIDIGER, Department of Psychology, University of Kentucky, Lexington, KY:

The Millon Clinical Multiaxial Inventory--III (MCMI-III) is a 175-item true-false self-report inventory for the assessment of psychopathology. Its major competing alternatives are the Minnesota Multiphasic Personality Inventory--II (MMPI-II; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989) and the Personality Assessment Inventory (PAI; Morey, 1991). Its principal advantages relative to these instruments are the inclusion of scales devoted to the diagnosis of the personality disorders included within the fourth edition of the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; APA, 1994). Personality disorders are placed on a separate axis in DSM-IV to encourage their diagnosis in clinical practice because they have been shown to have a substantial impact on the course and treatment of most other mental disorders (Widiger & Sanderson, 1995). The primary author of the MCMI-III has been a leading theorist in the diagnosis and classification of

personality disorders and was instrumental in the development of the diagnostic criteria for both the avoidant and passive-aggressive personality disorders.

However, the extent to which the MCMI-III scales are in fact coordinated with the DSM-IV personality disorders has been controversial (Zimmerman, 1994). There has been a substantial amount of research on the convergence of various editions of the MCMI with other personality disorder instruments. A surprising omission from the MCMI-III test manual is any reference to this extensive research. The research summarized within the manual is confined to unpublished validation studies conducted by the test authors. Studies published in peer-reviewed journals by independent researchers have generally indicated good to excellent convergence with respect to the assessment of the avoidant, dependent, borderline, and passive-aggressive personality disorders, but inconsistent, problematic, and perhaps even poor convergence for the obsessive-compulsive, antisocial, histrionic, and narcissistic personality disorders (Widiger & Sanderson, 1995). In fact, many studies have reported significant negative convergent validity coefficients for the Obsessive-Compulsive scale. It is problematic enough to fail to obtain convergent validity but, apparently, persons who elevate on the MCMI-III Obsessive-Compulsive scale might even be less likely to have this personality disorder than persons who do not obtain an elevation.

Some of the weak convergence appears to be attributable to a different emphasis within the MCMI-III scales on various components of, or theoretical model for, a respective personality disorder. For example, the MCMI-III scales for the assessment of the obsessive-compulsive, narcissistic, and histrionic personality disorders include a substantial proportion of items that assess adaptive rather than maladaptive functioning. The Histrionic scale includes items that assess adaptive gregariousness (e.g., #57: "I think I am a very sociable and outgoing person"; and #80: "It's easy for me to make many friends"), the Narcissistic scale includes items that assess normal, adaptive self-confidence (e.g., #40: "I guess I'm a fearful and inhibited person," keyed false; and #69: "I avoid most social situations because I expect people to criticize or reject me," keyed false), and the Obsessive-Compulsive scale includes items that assess normal, adaptive constraint (e.g., #22: "I'm a very erratic person, changing my mind and feelings all the time," keyed false; and #53: "Punishment never stopped me from doing what I wanted," keyed false). Persons with the respective personality disorder might endorse the item in the respective direction, but it is also evident that persons who do not have maladaptive personality traits would have to endorse these items in the same direction. Clinicians might consider readministering the MCMI-III after treatment has been completed. They may at times find that their psychotherapy has apparently created rather than cured their patient of narcissistic, histrionic, or obsessive-compulsive symptomatology, as scores on these scales have been shown to increase after treatment has been completed (Widiger & Saylor, 1998).

Potential limitations of items that assess adaptive rather than maladaptive functioning can be offset to some extent by confining their administration to persons known to have the respective symptomatology. The "normative data and transformation scores for the MCMI-III are based entirely on clinical samples and are applicable only to individuals who evidence problematic emotional and interpersonal symptoms or who are undergoing professional psychotherapy or a psychodiagnostic evaluation" (manual, 1997, p. 6). "An important feature that distinguishes the MCMI from other inventories is its use of actuarial base rate data rather than normalized standard score transformations" (manual, 1997, p. 5). Most other instruments determine cutoff points for scale interpretation on the basis of the extent of deviation from a population norm (e.g., Butcher et al., 1989; Morey, 1991). A limitation of such cutoff points is the false assumption that scale interpretation should be governed simply by statistical deviance. Cutoff

scores that are coordinated with the actual base rate of a disorder will provide more accurate diagnoses.

However, the advantages of using base rate data to set a cutoff point are lost if the prevalence rate for the disorder varies significantly across different settings. This was demonstrated vividly by Retzlaff (1996). Retzlaff noted that the 1994 version of the MCMI-III test manual failed to report the probability of having a disorder given the obtainment of a cutoff point. Retzlaff therefore calculated this probability using the data provided within the test manual. The probability values ranged from a low of .00 (Sadistic) to a high of only .32 (Histrionic). Sensitivity rates (proportion of persons with a disorder who obtained a particular cutoff point) ranged from a low of .00 (Sadistic) to a high of only .40 (Dependent). These were remarkably poor results, yet they were based on the test authors' own validation data provided within the MCMI-III manual. For example, only 4% of the persons with an antisocial personality disorder included within the test authors' own validation sample would have been identified by the MCMI-III's cutoff points.

The second edition of the MCMI-III test manual was published the following year, along with new sensitivity and probability values that were now within acceptable ranges (e.g., the Obsessive-Compulsive scale had a sensitivity of .73 rather than .07). There was no indication of what correction was made to the validation data, to the scales, or to the cutoff points that provided this substantial improvement. However, perhaps the lesson learned from Retzlaff (1996) is that the diagnostic accuracy of the scales may vary substantially across different clinical settings. As indicated by the test authors, "local base rates and cutting lines must still be developed for special settings" (manual, p. 5). Millon et al. (authors of the 2nd edition test manual) suggest that "the MCMI can be used on a routine basis in outpatient clinics, community agencies, mental health centers, college counseling programs, general and mental hospitals, independent and group practice offices, and in court" (manual, p. 5). However, clinicians working within clinical settings in which substantial clinical symptomatology is not commonplace (e.g., college counseling or divorce mediation center) might find that the MCMI-III overestimates the extent and breadth of psychopathology.

Millon, Davis, and Millon (1998) provide a supplementary manual for applications of the MCMI-III within correctional (prison) settings. As indicated in this manual, the MCMI-III Interpretive Report provided by the National Computer Systems would most likely be inaccurate within a prison setting. "BR (base rate) modifications were made for those [personality disorder scales] where differences in prevalence were found between correctional inmates and psychiatric patients" (Millon et al., 1998, p. 5). Adjustments are made to the cutoff points for eight of the personality disorder scales when administered to male inmates, and to six scales when administered to female inmates. "The norms for the other MCMI-III scales remain the same . . . because of their general applicability to diverse respondents" (Millon et al., 1998, p. 5). Surprisingly, no adjustments were made to the MCMI-III Antisocial Personality Disorder scale. The prevalence rate Millon et al. (1998) obtained for antisocial personality disorder symptomatology within their inmate setting was not substantially different from the base rate of antisocial symptomatology obtained by the MCMI-III in general psychiatric settings. In fact, Millon et al. (1998) indicated that if there is any difference, their research suggested that "male inmates are less likely than psychiatric patients to exhibit . . . antisocial (Scale 6A; 14.4% versus 17.9%) . . . characteristics" (p. 10). These findings are so discrepant from clinical expectations that some caution should perhaps still be exercised. Nevertheless, the effort of Millon et al.

(1998) to develop separate MCMI-III norms for different clinical settings is an important advance in the scoring of this instrument.

Clinicians could make their own corrections to the cutoff points based on their own estimates of the prevalence rates within their local setting. Hand-scoring templates for the scoring of the MCMI-III are available at minimal cost. However, clinicians might find these templates to be somewhat cumbersome. There are 14 steps to complete, some of which closely resemble a complicated tax form. This complexity is due largely to the admirable efforts of the test authors to make adjustments to each scale for the many different variables that can impact a particular test score (e.g., gender, setting, mood state, and response set). However, the test authors themselves estimate that it takes approximately 40-60 minutes to administer each hand-scoring template, which is appreciably longer than the 20-30 minutes it probably took for the respondent to complete the instrument. One might be better off using the 40-60 minutes to conduct a detailed interview of the patient.

SUMMARY. The MCMI-III is among the most popular self-report instruments for the assessment of personality disorders but given a number of important limitations it should be used with substantial caution and skepticism. Elevations on a particular scale should perhaps be interpreted as only suggestions for possible diagnoses that need to be verified with a systematic interview.

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The Millon Clinical Multiaxial Inventory (mcmii) is a useful instrument for the assessment of personality disorders and clinical syndromes. A recent survey on psychological test usage indicated that... Millon Clinical Multiaxial Inventory-III: manual. Minneapolis, MN: National Computer SystemsGoogle Scholar. Millon, T., & Davis, R. D. (1995). Based on Dr Theodore Millon's ground-breaking theory of personality and psychopathology, the MCMI-III (Millon Clinical Multiaxial Inventory-III) assessment provides one of the most well-researched and widely used measures of adult psychopathology available today. Valued for its brevity, the MCMI-III instrument helps quickly and accurately assess DSM-IV-related personality disorders and clinical syndromes. A hallmark of this proven instrument is its treatment-oriented Interpretive Report, which presents an integrated view of results. Mental health professionals around the world have come to rely on the MCMI-III. AbeBooks, an Amazon company, offers millions of new, used, and out-of-print books. Go to AbeBooks.com. Have one to sell? There is a newer edition of this item: MCMI-III Manual (Millon Clinical Multiaxial Inventory-III) Currently unavailable. The Amazon Book Review Author interviews, book reviews, editors' picks, and more. Read it now.