MACI®-II

Millon® Adolescent Clinical Inventory-II

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Interpretive Report with Grossman Facet Scales

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Name:	Sofia Sample
ID Number:	12345
Age:	14
Gender:	Female
Setting:	Clinic/group practice
Current School Grade:	9th Grade
Administration Language:	English
Date Assessed:	02/04/2020

[1.10 / 2 / QG]

MILLON ADOLESCENT CLINICAL INVENTORY–II

PROFILE SUMMARY—VALID

INVALIDITY (V) RAW SCORE = 0
INCONSISTENCY (W) RAW SCORE = 3

RESPONSE NEGATIVITY (X) RAW SCORE = 16
RESPONSE NEGATIVITY (X) PERCENTILE SCORE = 61

PERSONALITY PATTERNS		Score Raw	PR	BR	Profile of BR Scores 0 60 75 85 115
					Feature Trait Type
INT	1	5	44	60	
INH	2	17	91	100	
SUB	3	9	56	63	
DRA	4	1	2	8	
EGO	5	1	3	10	
UNR	6A	0	6	0	
FOR	6B	0	13	0	
CON	7	22	90	85	
DIS	8A	8	45	53	
AGG	8B	7	46	57	
BTE	9	8	50	60	

EXPRESSED CONCERNS		Score Raw	PR	BR	Profile of BR Scores 0 60 75 85 115
					Present Prominent
ID	A	10	75	80	
SD	B	14	86	105	
PI	C	9	78	85	
FD	D	2	31	30	

CLINICAL SYNDROMES		Score Raw	PR	BR	Profile of BR Scores 0 60 75 85 115
					Present Prominent
BE	AA	6	86	69	
SA	BB	4	83	68	
DP	CC	0	9	0	
AF	DD	14	76	95	
DA	EE	10	67	79	
ST	FF	4	72	63	
DM	GG	1	17	10	
PT	HH	4	53	60	
RD	II	6	60	52	

MILLON ADOLESCENT CLINICAL INVENTORY–II

FACET SCALES FOR HIGHEST ELEVATED PERSONALITY SCALES

FACET SCALES		Score Raw	Score PR	Profile of PR Scores 0 50 75 100
INH	**2**			Interpretable
Expressively Fretful	2.1	7	60	
Interpersonally Aversive	2.2	6	70	
Alienated Self-Image	2.3	8	82	
CON	**7**			
Expressively Disciplined	7.1	13	99	
Interpersonally Respectful	7.2	10	70	
Conscientious Self-Image	7.3	6	69	
SUB	**3**			
Interpersonally Docile	3.1	7	63	
Temperamentally Pacific	3.2	11	88	
Expressively Incompetent	3.3	8	72	

GROSSMAN FACET SCALE SCORES

		Raw	PR
1	**Introversive**		
1.1	Expressively Impassve	3	59
1.2	Temperamentally Apathetic	2	51
1.3	Interpersonally Unengaged	4	64
2	**Inhibited**		
2.1	Expressively Fretful	7	60
2.2	Interpersonally Aversive	6	70
2.3	Alienated Self-Image	8	82
3	**Submissive**		
3.1	Interpersonally Docile	7	63
3.2	Temperamentally Pacific	11	88
3.3	Expressively Incompetent	8	72
4	**Dramatizing**		
4.1	Interpersonally Attention-Seeking	3	24
4.2	Gregarious Self-Image	2	16
4.3	Temperamentally Fickle	0	3
5	**Egotistic**		
5.1	Admirable Self-Image	0	5
5.2	Cognitively Expansive	2	20
5.3	Interpersonally Exploitive	0	10
6A	**Unruly**		
6A.1	Expressively Impulsive	0	8
6A.2	Acting-Out Mechanism	0	11
6A.3	Interpersonally Irresponsible	0	7
6B	**Forceful**		
6B.1	Interpersonally Abrasive	1	46
6B.2	Expressively Precipitate	0	6
6B.3	Temperamentally Hostile	1	32
7	**Conforming**		
7.1	Expressively Disciplined	13	99
7.2	Interpersonally Respectful	10	70
7.3	Conscientious Self-Image	6	69
8A	**Discontented**		
8A.1	Dispirited Self-Image	3	62
8A.2	Expressively Resentful	4	39
8A.3	Interpersonally Contrary	0	8
8B	**Aggrieved**		
8B.1	Cognitively Diffident	7	73
8B.2	Undeserving Self-Image	4	58
8B.3	Temperamentally Dysphoric	4	70
9	**Borderline Tendency**		
9.1	Temperamentally Labile	5	62
9.2	Interpersonally Paradoxical	3	41
9.3	Uncertain Self-Image	4	56

The following interpretive report is based on normative data that were obtained from 13- to 18-year-olds who were being seen in professional treatment settings for emotional, behavioral, social and/or academic problems. Exaggerated statements of severity may be reported for respondents who took the MACI–II for purposes other than clarification of such clinical concerns and scores reported for respondents who do not fit the normative profile may not be accurate. Further, owing to fluctuations in emotion, behavior, cognition, and self-awareness that are characteristic of this age group, the report should be considered a "snapshot" of this adolescent's emerging and changeable psychological attitudes, behavioral patterns, and self-perceptions.

Note that this report is based in part on psychological inferences in addition to empirical correlates with clinical judgment. It is, therefore, composed of probabilistic statements. The MACI–II report cannot be considered definitive and should be employed as one component of a thorough clinical evaluation. Scores in this report should be evaluated by a qualified mental health clinician trained in the use of psychological tests and should not be shown directly to either the adolescent or their parent(s) or guardian(s) without careful consideration and clinical discretion.

INTERPRETIVE CONSIDERATIONS

In addition to the preceding considerations, the interpretive narrative should be evaluated in light of the following demographic and situational factors. This 14-year-old is currently in the 9th grade. In the demographic portion of the test, she identifies "self-confidence" and "social life" as the problems that are troubling her the most.

This adolescent's score on the Response Negativity scale is at the 61st percentile, placing it in the middle 50% of scores (i.e., the 25th through 75th percentile) obtained by the MACI–II normative sample. This middle-range score suggests that it is unlikely that she substantially underreported or overreported problems when completing the inventory.

PERSONALITY PATTERNS

This section of the interpretive report pertains to those relatively enduring and potentially pervasive personality characteristics that underlie the interpersonal and intrapersonal difficulties this adolescent may have. With adolescents, it is important to note that these personality characteristics can manifest themselves at different frequency rates and intensity levels depending on the setting, situation, and people around them while, at the same time, remaining consistent with the essence of their origins and motivating strategies. It is further noted that these characteristics tend to perpetuate themselves so that they become more stable over time. This section outlines the more habitual ways in which this adolescent behaves, thinks, feels, and relates.

This MACI–II profile is suggestive of an adolescent who is often seen as sensitive and shy. She tends to be cautious in getting close to others and selective in regard to who her friends are. Trust is a valuable commodity, something that others must earn. There is an underlying desire for acceptance and approval, but an apprehensiveness and hesitancy to take chances. She harbors some concerns about making mistakes and bringing negative attention to herself. Her emotions will lean toward nervousness or embarrassment. A sense of empathy has been built on these experiences.

It appears that this adolescent has had limited opportunities in which she felt safe and secure. Her current profile suggests that she has a fearful mistrust of others and she will flatten her emotions in an effort to protect herself and lessen her apprehension. She exhibits shyness and a chronic social unease that stems from a pattern of avoiding close peer and family relationships. While she desires closeness and affection, she has self-protectively restrained this need to the extent that there may be little spark and vitality to her current existence. Despite efforts

to dampen her feelings, she does experience both recurrent anxiety about her low social status and pervasive negative moods. Her thoughts about her self-esteem and social life are often so distressing that they create confusion and lead to further preoccupations and withdrawal. The more she turns inward, however, the more she may lose contact with others and common adolescent interests.

This adolescent is hesitant to initiate social contacts, shies away from competitive situations, and struggles to enjoy the lighter side of teenage life. She will be very selective in her search for supportive persons, groups, or organizations since she is overconcerned with the humiliation of social rebuff and anticipates rejection. Chronic self-deprecation of her aptitudes serves to mitigate these concerns. She is hypersensitive to signs of potential rejection and tends to over-interpret minor slights and construe them as indicators of future derision or ridicule. Despite her strong desire to be accepted and cared for, she has felt it best to suppress these affiliative needs and maintain a safe distance from others whom she believes eventually will prove hurtful. She has also learned that by fading into the background, assuming a passive role, and willingly submitting to the expectations of others, she will be relatively untroubled. As a consequence, she is likely to have withdrawn into increasingly peripheral social, academic, and family roles. Her self-image of being unworthy and undesirable makes ordinary demands and relationships often seem frightening and potentially dangerous. In addition to an expectation of humiliation and rejection, her withdrawal may stem from a chronic behavioral apathy and low energy level. Her sluggish exterior and affective blandness may be deceptive, however, concealing restrained anger and anxiety as well as feelings of depression and hopelessness.

Given her limited social contacts, it is probable that this adolescent often engages in solitary activities or spends much of her time engaged in remote dealings that require limited social involvement. At times, she may daydream or report being distracted by inner thoughts that intrude upon her attention to everyday affairs. To counteract these thoughts, she is likely to have learned to suppress events that could stir up disturbing memories and feelings. All of her defensive efforts may prove self-reinforcing since she may miss out on opportunities to have socially rewarding experiences and to develop effective social skills. Together with her characteristic affective restraint and withdrawn behavior, her shyness and fearfulness do little to bring favorable attention and interest from peers or adults. As a consequence, she may drift further into a detached, anxious, and isolated life pattern.

GROSSMAN FACET SCALES

The Grossman facet scales are designed to facilitate interpretation of elevations on the Personality Patterns scales by helping to pinpoint the specific personality processes (e.g., self-image, interpersonal relations) that underlie overall scale elevations. A careful analysis of this adolescent's facet scale scores suggests that the following characteristics are among her most prominent personality features.

Most notable is a tendency to construct the world in terms of proper rules and regulations. Though not without its positive aspects, this tendency results in being unimaginative and becoming upset by unfamiliar events or customs. She tends to be inflexible if not stubborn about adhering to conventional or formal schemas for organizing and shaping her life. Preferring routines and predictability, she can easily be thrown off balance by having to deal with novel experiences and ideas. In these circumstances, she will often feel unsure about what course of action to take, thereby sometimes ending up immobilized and indecisive.

Also salient is the presence of adaptable inclinations and behavioral passivity, simple if not immature impulses and expectations, and limited competencies. She probably has a biologic propensity or has learned through parental models to behave affectionately and admiringly. Also, she may possess an ingrained disposition for expressing tenderness and consideration, essential elements in holding on to protectors. Having learned the "peaceable" role well allows this adolescent to provide peers with the feeling that they are useful, sympathetic, and more competent.

Also worthy of attention is this adolescent's feeling of aloneness and undesirability, further complicated by a tendency to devalue positive qualities, resulting in the sense of being repeatedly derogated and socially isolated. She may be notably self-conscious, have a self-view as someone who is inferior to others, and harbor insecurities regarding social acceptance and self-worth. The alienation she feels from others is paralleled by a feeling of self-alienation.

Early management and treatment efforts are likely to produce optimal results if they are oriented toward modifying the personality features just described.

EXPRESSED CONCERNS

The scales in this section pertain to this adolescent's perceptions concerning key issues of psychological development and concern. Since experiences at this age are notably subjective, it is important to record this adolescent's self-perceptions of identity, self-esteem, and relationships. For comparative purposes, this adolescent's attitudes and beliefs regarding a range of personal, social, and familial matters are contrasted with those expressed by a broad cross section of adolescents of similar age with clinical problems.

This adolescent reports pervasive feelings of low self-esteem and dissatisfaction. There is a negative sense of self, which is managed by amplifying perceived flaws or shortcomings and downplaying positive attributes or real achievements. Harboring self-doubts and a pessimistic outlook, she is often defeated before even getting started or taking a chance. She anticipates falling far short of aspirations and a low self-regard and lack of fulfillment permeate most aspects of her functioning.

Peer relationships are a major source of distress for this adolescent. There is a strong sense of rejection from peers as well as feelings of sadness and loneliness over not gaining acceptance and approval from them. This adolescent's self-confidence has been shaken to the point of doubting her likability and anticipating that others will be judgmental or critical. Fears that efforts to fit in will lead to more rejection may be lessened, to a degree, by withdrawing in a self-protective manner.

This adolescent is struggling to establish a positive and consistent identity. She reports feelings of confusion and uncertainty regarding her sense of self, values, and goals. Unclear about personal strengths, she struggles to direct and sustain attention and energies into activities that could prove worthwhile and rewarding. There is a subjective sense that many peers are more sure than she is of who they are and what they want in the future.

CLINICAL SYNDROMES

The features and dynamics of the following distinctive clinical syndromes are worthy of description and analysis. Although they may arise in response to external precipitants, it is probable that each syndrome's presentation reflects and accentuates the enduring and pervasive aspects of this adolescent's basic personality style.

Evidence indicates the presence of clinically significant levels of anxiety in this adolescent. Broad and generalized symptoms would be consistent with this overall personality style: pervasive social discomfort, apprehensiveness over small matters, and ruminative self-doubts. Additionally, frequent somatic complaints may include fatigue, headaches, stomachaches, and other pains and ailments that interfere with daily functioning. She has few friends, fears rejection or humiliation, and often seems overwhelmed by the demands and responsibilities of everyday life. Lacking self-esteem and self-confidence, she does not assert her needs or mobilize in a proactive manner. Instead, there is a strong tendency to mull over worries and fears, internalizing and intensifying overall distress.

There is evidence of a recent increase in depressive symptoms in this socially apprehensive, sensitive, and introverted adolescent. A level of sadness and despondency is exhibited that is consistent with a persistent depressive condition. This adolescent's current state is notable for a diminished level of energy, interest, and pleasure in activities that were enjoyed in the past. Now, much of the time, she is preoccupied with matters of personal adequacy, recurring self-doubts, and feeling disconnected from others. Often sad, empty, and lonely, there are likely to be deep and frustrated yearnings for social acceptance. At the same time, though, she has retreated from peers. Maintaining a safe distance from them lessens the chances of rejection or embarrassment. Lacking social supports and lacking self-confidence contributes to a vulnerability to enduring prolonged feelings of loneliness and despair.

NOTEWORTHY RESPONSES

This adolescent answered the following statements in the direction noted in parentheses beside the item. These items suggest specific problem areas that the clinician may wish to investigate. Additionally, the number of items in each response category endorsed by this adolescent is listed beside each category, followed by the total number of items in each category.

Vengefully Prone (0/3)

No items.

Suicidal Thoughts (0/3)

No items.

Non-suicidal Self-injury (1/2)

55. Item Content Omitted (True)

Traumatic Experiences (1/4)

84. Item Content Omitted (True)

Lapses in Reality Testing (0/3)

No items.

Despondency-Despair (4/4)

2. Item Content Omitted (True)
44. Item Content Omitted (True)
77. Item Content Omitted (True)
117. Item Content Omitted (True)

Bipolar Spectrum (0/3)

No items.

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.

Explosive Anger (0/3)

No items.

Impulse Control Problems (0/3)

No items.

Instrumental Anger (0/3)

No items.

Alcohol/Drug Use (1/2)

11. Item Content Omitted (True)

Eating Concerns (0/3)

No items.

DIAGNOSTIC CONSIDERATIONS

The following diagnostic considerations should be viewed as judgments of personality and clinical prototypes that correspond conceptually to formal diagnostic categories. Although the diagnostic criteria and items used in the MACI–II differ somewhat from those in the *DSM–5*®, there are sufficient parallels to recommend consideration of the following assignments. More definitive judgments should draw upon biographical, observational, and interview data in addition to self-report inventories such as the MACI–II.

Personality Types, Traits, and Features

Although traits and features of personality disorders are often observable in adolescents, the data from the MACI–II should not be used to assign diagnostic labels without additional clinical information. Even when assigned, diagnostic labels tend to be less stable for adolescents than for adults. The traits listed below are suggested by the MACI–II results and may be important adjuncts to the diagnostic process.

Inhibited (Avoidant) Personality Type
with Conforming (Compulsive) Traits
and Submissive (Dependent) Features

Clinical Syndromes

The following list contains suggested clinical syndromes and other conditions relating to the *DSM–5*® that may be a focus of clinical attention.

300.02 (F41.1) Generalized Anxiety Disorder
Also consider:
300.23 (F40.10) Social Anxiety Disorder (Social Phobia)

309.0 (F43.21) Adjustment Disorder with Depressed Mood

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.

V62.4 (Z60.4) Social Exclusion or Rejection

TREATMENT GUIDE

Treatment efforts for this introversive and anxious adolescent are best directed toward countering her withdrawal tendencies. Minimally introspective and exhibiting diminished affect and energy, she must be encouraged to become more socially engaged and to avoid becoming totally isolated. It is probable that attempts will be made to meet school and family obligations; however, there is a preference for solitary activities or those that require minimal face-to-face contact. Limiting interpersonal contacts precludes exposure to new experiences. While this is preferred, such behavior only fosters a withdrawn and isolated existence. Therefore, the clinician should ensure continuation of some social activity, preferably based on this adolescent's interests and aptitudes, in order to prevent becoming lost in asocial and fantasy-based preoccupations or become separated from reality-based contacts. At the same time, encouragement of excessive social activity should be avoided because this may exceed her tolerance for stress and it is probable that she needs to further develop social skills.

The importance of the relational treatment component cannot be overstated and it will be necessary since treatment may proceed at a slow pace. Initially, eye contact and verbal output may be limited. Improvements in these areas can be enhanced with positive reinforcement and the gradually increased use of open-ended questions. She may need guidance in learning how to identify emotions and make connections between body reactions, thoughts, and feelings. Therapy could help increase perceptual awareness and help her become more discriminating of personal experiences. The clinician should be patient and provide consistent support because this adolescent has an underlying conflict between wanting acceptance and fearing rejection and being in a vulnerable position. At times, therapy may seem too self-revealing or risk-taking. Exploration of thoughts and feelings can be translated into setting reasonable and safe goals to pursue.

Techniques of behavior modification may be valuable in developing new social skills. Starting in individual therapy sessions, role plays can help improve conversation and perspective taking skills. She can participate in setting goals in terms of frequency of social interaction and joining a club or organization as well as connecting with peers through social media. In the cognitive sphere, it would be important to identify automatic thoughts, attitudes, and assumptions that reinforce withdrawal tendencies. Testing for their veracity can gradually lead to cognitive restructuring and the identification of more helpful thoughts. Periodic family therapy sessions would allow the clinician to assess family communication and interaction styles, some of which may model or reinforce isolation from each other. As a result, enlisting family members to participate in reaching this adolescent's treatment goals may extend to setting family goals. Furthermore, combining group therapy sessions with individual therapy sessions would provide an opportunity to increase social interaction. Goals in group treatment could include learning to attend to and interpret social signals and messages that others communicate as well as learning how to respond in meaningful, reciprocal, and empathic ways.

Efforts to enhance this adolescent's social interest must proceed in a deliberate and systematic manner so as not to push her beyond tolerable limits. Empathic and well-reasoned therapeutic communication may advance a willingness to adopt more positive and realistic beliefs about self and others. The clinician should be cognizant of the areas of life in which this adolescent possesses positive emotional inclinations and should encourage engagement in activities consistent with those tendencies in order to promote a more vibrant and rewarding lifestyle.

End of Report

ITEM RESPONSES

1:	1	2:	1	3:	1	4:	2	5:	2	6:	1	7:	2	8:	1	9:	1	10:	2
11:	1	12:	2	13:	2	14:	2	15:	2	16:	2	17:	2	18:	2	19:	2	20:	2
21:	2	22:	1	23:	2	24:	2	25:	1	26:	1	27:	2	28:	2	29:	2	30:	1
31:	2	32:	2	33:	1	34:	1	35:	2	36:	2	37:	2	38:	2	39:	2	40:	2
41:	2	42:	1	43:	1	44:	1	45:	2	46:	1	47:	2	48:	1	49:	2	50:	2
51:	2	52:	2	53:	2	54:	2	55:	1	56:	1	57:	2	58:	1	59:	2	60:	2
61:	1	62:	2	63:	1	64:	2	65:	1	66:	1	67:	1	68:	2	69:	2	70:	2
71:	2	72:	2	73:	2	74:	2	75:	2	76:	2	77:	1	78:	2	79:	2	80:	2
81:	1	82:	2	83:	2	84:	1	85:	1	86:	1	87:	2	88:	2	89:	2	90:	2
91:	2	92:	2	93:	2	94:	1	95:	2	96:	2	97:	2	98:	2	99:	1	100:	1
101:	2	102:	2	103:	2	104:	2	105:	1	106:	2	107:	1	108:	2	109:	2	110:	2
111:	2	112:	2	113:	2	114:	1	115:	2	116:	2	117:	1	118:	1	119:	2	120:	2
121:	1	122:	2	123:	2	124:	2	125:	2	126:	1	127:	1	128:	1	129:	2	130:	2
131:	2	132:	1	133:	2	134:	1	135:	1	136:	1	137:	1	138:	2	139:	2	140:	2
141:	2	142:	2	143:	2	144:	1	145:	2	146:	1	147:	2	148:	2	149:	2	150:	2
151:	2	152:	2	153:	2	154:	2	155:	2	156:	2	157:	2	158:	1	159:	1	160:	2