MCMI®-IV

MILLON® CLINICAL
MULTIAXIAL INVENTORY–IV

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

Name:	Joan Sample
ID Number:	123456789
Age:	29
Gender:	Female
Setting:	Outpatient never hospitalized
Education:	Bachelor's degree or more
Race:	Hispanic
Marital Status:	Never Married
Date Assessed:	10/09/2015

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 29-year-old single Hispanic female with a bachelor's degree or more. She is currently being seen as an outpatient, and she reports that she has recently experienced a problem that involves low self-confidence. These self-reported difficulties, which have occurred for an unspecified period of time, may take the form of a clinical syndrome disorder.

This patient's test results are of questionable validity due to the possibility of random responding. For that reason, the test scores and interpretive text that follow should be viewed with caution.

This patient's response style may indicate a tendency to magnify illness, an inclination to complain, or feelings of extreme vulnerability associated with a current episode of acute turmoil. The patient's scale scores may be somewhat exaggerated, and the interpretations should be read with this in mind.

Profile Severity

On the basis of the test data, it may be assumed that the patient 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.

Possible Diagnoses

She appears to fit the following personality disorder classifications best: Borderline Personality Disorder, and Unspecified Personality Disorder (Negativistic) Disorder, with Antisocial Personality Type, and Unspecified Personality Disorder (Melancholic) Style.

Clinical syndromes are suggested by the patient's MCMI-IV profile in the areas of Major Depression (recurrent, severe), Alcohol Use Disorder, and Adjustment Disorder with Anxiety.

Therapeutic Considerations

Sulky and discontented, this person is overly reactive to the attitudes and demands of others, perceiving them as a cause for her resentment and complaints. Likely to be upset and irritable, she may not readily comply with treatment recommendations unless they are focused and of a short-term character. Firm, consistent, understanding attitudes, along with frequent follow-up sessions may be needed to maximize compliance and progress.

MILLON CLINICAL MULTIAXIAL INVENTORY-IV

PROFILE SUMMARY

HIGH-POINT CODE = 8A 6A 2B
BR ADJUSTMENTS = X, A/CC

INVALIDITY (V) = 0
INCONSISTENCY (W) = 14

VALIDITY		Score Raw	Score BR	Profile of BR Scores 0 35 75 100
Modifying Indices				Low / Average / High
Disclosure	X	75	88	
Desirability	Y	12	60	
Debasement	Z	24	88	

PERSONALITY		Score Raw	Score PR	Score BR	Profile of BR Scores 0 60 75 85 115
Clinical Personality Patterns					Style / Type / Disorder
AASchd	1	11	64	66	
SRAvoid	2A	10	58	70	
DFMelan	2B	22	84	78	
DADepn	3	11	71	73	
SPHistr	4A	13	53	62	
EETurbu	4B	15	59	65	
CENarc	5	10	74	69	
ADAntis	6A	17	99	92	
ADSadis	6B	10	75	68	
RCComp	7	10	16	40	
DRNegat	8A	24	99	96	
AAMasoc	8B	13	72	71	
Severe Personality Pathology					
ESSchizoph	S	12	65	65	
UBCycloph	C	24	99	97	
MPParaph	P	10	75	71	

PSYCHOPATHOLOGY		Score Raw	Score PR	Score BR	Profile of BR Scores 0 60 75 85 115
Clinical Syndromes					Present / Prominent
GENanx	A	7	57	78	
SOMsym	H	8	59	66	
BIPspe	N	5	38	58	
PERdep	D	26	97	107	
ALCuse	B	6	92	83	
DRGuse	T	5	74	67	
P-Tstr	R	4	48	60	
Severe Clinical Syndromes					
SCHspe	SS	12	68	64	
MAJdep	CC	16	79	86	
DELdis	PP	4	74	64	

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
UBCycloph	**C**				Interpretable
Uncertain Self-Image	C.1	8	95	85	
Split Architecture	C.2	8	90	78	
Temperamentally Labile	C.3	9	98	85	
DRNegat	**8A**				
Expressively Embittered	8A.1	7	94	83	
Discontented Self-Image	8A.2	7	79	75	
Temperamentally Irritable	8A.3	7	88	80	
ADAntis	**6A**				
Interpersonally Irresponsible	6A.1	5	87	75	
Autonomous Self-Image	6A.2	8	99	90	
Acting-Out Dynamics	6A.3	2	61	64	

GROSSMAN FACET SCALE SCORES

		Raw	PR	BR
1	**Schizoid**			
1.1	Interpersonally Unengaged	2	38	60
1.2	Meager Content	4	57	64
1.3	Temperamentally Apathetic	6	82	75
2A	**Avoidant**			
2A.1	Interpersonally Aversive	3	41	60
2A.2	Alienated Self-Image	5	70	75
2A.3	Vexatious Content	5	76	77
2B	**Melancholic**			
2B.1	Cognitively Fatalistic	6	70	75
2B.2	Worthless Self-Image	7	90	85
2B.3	Temperamentally Woeful	6	76	78
3	**Dependent**			
3.1	Expressively Puerile	6	79	75
3.2	Interpersonally Submissive	3	70	70
3.3	Inept Self-Image	4	66	70
4A	**Histrionic**			
4A.1	Expressively Dramatic	3	70	70
4A.2	Interpersonally Attention-Seeking	6	52	65
4A.3	Temperamentally Fickle	6	53	64
4B	**Turbulent**			
4B.1	Expressively Impetuous	5	69	70
4B.2	Interpersonally High-Spirited	6	71	70
4B.3	Exalted Self-Image	1	10	15
5	**Narcissistic**			
5.1	Interpersonally Exploitive	5	84	75
5.2	Cognitively Expansive	4	40	48
5.3	Admirable Self-Image	3	83	75
6A	**Antisocial**			
6A.1	Interpersonally Irresponsible	5	87	75
6A.2	Autonomous Self-Image	8	99	90
6A.3	Acting-Out Dynamics	2	61	64
6B	**Sadistic**			
6B.1	Expressively Precipitate	6	90	75
6B.2	Interpersonally Abrasive	5	93	75
6B.3	Eruptive Architecture	5	90	75
7	**Compulsive**			
7.1	Expressively Disciplined	4	42	60
7.2	Cognitively Constricted	7	66	68
7.3	Reliable Self-Image	1	1	10
8A	**Negativistic**			
8A.1	Expressively Embittered	7	94	83
8A.2	Discontented Self-Image	7	79	75
8A.3	Temperamentally Irritable	7	88	80
8B	**Masochistic**			
8B.1	Undeserving Self-Image	8	84	75
8B.2	Inverted Architecture	5	79	72
8B.3	Temperamentally Dysphoric	2	22	36
S	**Schizotypal**			
S.1	Cognitively Circumstantial	4	60	63
S.2	Estranged Self-Image	5	70	66
S.3	Chaotic Content	6	90	75
C	**Borderline**			
C.1	Uncertain Self-Image	8	95	85
C.2	Split Architecture	8	90	78
C.3	Temperamentally Labile	9	98	85
P	**Paranoid**			
P.1	Expressively Defensive	1	28	30
P.2	Cognitively Mistrustful	6	97	85
P.3	Projection Dynamics	5	87	77

RESPONSE TENDENCIES

This patient's test results are of questionable validity due to the possibility of random responding. She received an unusually high score on the Inconsistency (W) scale, meaning that a number of her responses to pairs of items that are similar in content are contradictory, as shown below. This suggests lack of responsiveness to the content of the items.

Inconsistency (W) Scale

143. Item Content Omitted
125. Item Content Omitted

47. Item Content Omitted
157. Item Content Omitted

81. Item Content Omitted
116. Item Content Omitted

25. Item Content Omitted
94. Item Content Omitted

39. Item Content Omitted
59. Item Content Omitted

33. Item Content Omitted
89. Item Content Omitted

78. Item Content Omitted
164. Item Content Omitted

171. Item Content Omitted
38. Item Content Omitted

74. Item Content Omitted
115. Item Content Omitted

26. Item Content Omitted
99. Item Content Omitted

20. Item Content Omitted
174. Item Content Omitted

13. Item Content Omitted
112. Item Content Omitted

162. Item Content Omitted
60. Item Content Omitted

149. Item Content Omitted
15. Item Content Omitted

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.

Common reasons for random responding include reading or language limitations, difficulty maintaining attention, cognitive impairment, carelessness, fatigue, and deliberate uncooperativeness. The possibility that one or more of these factors affected the patient's test responses should be investigated. In the meantime, the test results should be interpreted with caution.

This patient's response style may indicate a broad tendency to magnify the level of experienced illness or a characterological inclination to complain or to be self-pitying. On the other hand, the response style may convey feelings of extreme vulnerability that are associated with a current episode of acute turmoil. Whatever the impetus for the response style, the patient's scale scores, particularly those on Clinical Syndrome scales, may be somewhat exaggerated, and the interpretation of this profile should be made with this consideration in mind. Scores have been adjusted based on the Disclosure scale to compensate for a potential over reporting of actual symptoms.

Scores have been adjusted based on the Disclosure scale to compensate for a potential over reporting of actual symptoms. Scores for scales 2B (Melancholic), 8B (Masochistic), and C (Borderline) have been adjusted based on scales A (Generalized Anxiety) and CC (Major Depression) to compensate for the potential over reporting of symptoms based on the elevated scores from scales A and CC. Additional score adjustments have also been made on scores for scales 2A (Avoidant) and S (Schizotypal).

PERSONALITY PATTERNS

The following paragraphs refer to those enduring and pervasive personality traits that underlie this woman's emotional, cognitive, and interpersonal difficulties. Rather than focus on the largely transitory symptoms that make up clinical syndromes, this section concentrates on her more habitual and maladaptive methods of relating, behaving, thinking, and feeling.

The results of this assessment suggest that at least a moderate degree of pathology characterizes the overall personality organization of this woman. Her profile indicates a lack of internal cohesion wherein basic intentions and interaction with others tend toward conflictual motivation. A pronounced ambivalence typifies her behaviors and relationships, creating emotional lability and a distorted sense of others and their circumstances. The inner template on which she relies for understanding and interpreting reality is likely to be compromised, and her sense of psychic coherence is often precarious. Conflicts in social and personal relationships may be apparent, as well as a tendency to create self-defeating vicious circles and contraindicated interpersonal exchanges. Although she is typically able to function adequately, periods of marked emotional, cognitive, or behavioral dysfunction are likely.

The MCMI-IV profile of this woman suggests highly variable and unpredictable moods, an embittered and resentful irritability, an untrusting and pessimistic outlook, and the feeling of being cheated, misunderstood, and unappreciated. Lacking empathy and tolerance, she may exhibit coarse incivility and a ruthless indifference to the welfare of others. Displaying rash emotionality, she may express momentary thoughts and feelings impulsively, and she can be provoked into sudden and unpredictable hostility. A pattern of negativism, sulking, faultfinding, and stubbornness may be punctuated periodically by belligerent and querulous outbursts.

This woman anticipates being disillusioned in relationships with others and, for this reason, often behaves obstructively and thereby creates the expected disappointment. She may be deeply untrusting, fearful of domination, and suspiciously alert to efforts that might undermine her desires. Personal relationships may be fraught with wrangles and antagonism, often provoked by her bitter complaining, passive-aggressive behavior, touchiness, and irascible demeanor. The struggle between restraining her resentment and explosive anger and the conflict between dependency and autonomy may permeate most aspects of her life. She is likely to display an unpredictable and rapid succession of moods. Moreover, she may be restless, capricious, erratic, and easily offended by trifles.

A low tolerance for frustration may be notable as is a vacillation between being distraught and despondent and being irrationally negativistic and contentious. As a result, she may have been stereotyped as a person who

dampens the spirits of others: a malcontent who demoralizes and makes everyone close to her miserable. Her sulking and unpredictable behavior may induce others to react in a similarly inconsistent manner. As a consequence, she may feel misunderstood and unappreciated, and tends to be extremely touchy, defensive, and suspicious.

This woman often views others as devious and hostile, and she may repeatedly distort their incidental remarks to make them appear deprecating and vilifying. She may maintain alert vigilance against the possibility of attack or derogation. Desires for retribution for past mistreatment may underlie her characteristic hostility, envy, and suspiciousness. Unfortunately, this behavior sets in motion a self-fulfilling prophecy by driving away potential well-wishers and creating unnecessary friction, thereby confirming and justifying her pattern of resentment and hostility.

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 her most prominent personality features.

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

Also salient is the presence of marked confusion owing to her nebulous self-worth and wavering sense of identity, which leads to rapidly changing self-presentations and frequently self-punitive behavior. She remains aimless, unable to channel her energies or abilities, and incapable of settling on a path or role that might provide a basis for fashioning a unified and enduring sense of self. Her desire to redeem her unexpected actions and changing self-presentations accounts in part for her expressions of contrition and her self-punitive behavior.

Also worthy of attention is her erratically changing moods that shift from normality to depression to excitement. Chronic feelings of dejection and apathy may be frequently interspersed with brief spells of anger, euphoria, and anxiety. The intensity of her affect and the changeability of her actions are striking. Her unstable mood levels are rarely in accordance with external reality. She may exhibit a single, dominant outlook or temperament, such as a self-ingratiating depressive tone, which periodically gives way to anxious agitation or impulsive outbursts of anger or resentment. Although she may engage in self-destructive behavior, she typically recognizes the irrational and foolish nature of it afterwards.

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 woman's basic personality makeup.

Although atypical for this irritable and conflicted woman, she exhibits a pattern of dysphoric symptomatology indicative of a major depressive disorder. Agitated and erratic, her condition is likely to fluctuate between expressions of self-deprecation and despair. Both of these may be mixed with thoughts of suicide and an anxious sense of hopelessness, as well as outbursts of bitter discontent and irrational demands. Feeling trapped by

constraints imposed by her circumstances and upset by emotions and thoughts she can neither understand nor control, she may turn her anger inward, becoming severely intropunitive and self-loathing. These signs of contrition may serve to induce guilt in others, serving as an effective manipulation by which she can gain a measure of reprisal without further jeopardizing what she sees as her currently precarious situation.

Although not characteristic of this irritable woman's personality, her pattern of MCMI-IV responses suggest that she is experiencing a persistent depressive disorder that is marked by agitated and erratic qualities. She is likely to fluctuate between expressions of self-deprecation and despair, both of which may be mixed with an anxious sense of hopelessness and futility, and outbursts of bitter discontent and irrational demands. Feeling trapped by constraints imposed by her circumstances and thrown off balance by emotions and thoughts she cannot understand or control, she may turn her anger inward and become severely intropunitive and self-loathing. These signs of contrition may induce feelings of guilt in others, serving as an effective manipulation by which she can gain a measure of retribution without further jeopardizing her already precarious situation.

This woman's MCMI-IV responses suggest that she may be subject to periods of alcohol abuse, particularly during times of loneliness, disappointment, or resentment. Generally disposed to vent her brittle and unstable emotions, she may become volatile and destructive when she drinks heavily. Her expressions of discontent and dissatisfaction may be followed by guilt and contrition, but her anger and reproach may not often subside. Rather, they are frequently aired in accusatory statements, irrational jealousies, and deft recriminations toward others. Moreover, a strong self-destructive aspect of her drinking compels her to undermine her good fortunes as well as those of others who she feels have let her down.

Typically conflicted, resentful, and irritable, this woman's characteristic personality style appears to be complicated by symptoms of a generalized anxiety disorder. Headaches, insomnia, and fatigue may be present, as well as behavioral symptoms such as distractibility, apprehensiveness, and fearful presentiments. These symptoms are likely to be the products of unresolved inner conflicts that have recently risen to the surface, upsetting the usual ease with which she discharges her anger and resentment. Unsure of how to counteract these conflicts, she may exploit them to criticize and manipulate others.

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.

Health Preoccupied

120. Item Content Omitted (True)
146. Item Content Omitted (True)

Interpersonally Alienated

4. Item Content Omitted (True)
190. Item Content Omitted (True)

Emotional Dyscontrol

45. Item Content Omitted (True)
72. Item Content Omitted (True)
80. Item Content Omitted (True)

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Self-Destructive Potential

14. Item Content Omitted (True)
32. Item Content Omitted (True)
34. Item Content Omitted (True)
39. Item Content Omitted (True)
101. Item Content Omitted (True)
114. Item Content Omitted (True)
151. Item Content Omitted (True)
164. Item Content Omitted (True)

Childhood Abuse

47. Item Content Omitted (True)

Vengefully Prone

22. Item Content Omitted (True)
37. Item Content Omitted (True)
111. Item Content Omitted (True)
167. Item Content Omitted (True)
178. Item Content Omitted (True)
192. Item Content Omitted (True)

Explosively Angry

11. Item Content Omitted (True)
74. Item Content Omitted (True)
168. Item Content Omitted (True)
191. Item Content Omitted (True)

Autism Spectrum

179. Item Content Omitted (True)
190. Item Content Omitted (True)

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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.

296.33 (F33.2) Major Depression (recurrent, severe)
305.00 (F10.10) Alcohol Use Disorder
309.24 (F43.22) Adjustment Disorder with Anxiety

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:

301.83 (F60.3) Borderline Personality Disorder
301.9 (F60.9) Unspecified Personality Disorder (Negativistic) Disorder
with Antisocial Personality Type
and Unspecified Personality Disorder (Melancholic) 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 her 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.

Low Self-Confidence

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.

As a first step, it would appear advisable to implement methods to ameliorate this patient's current state of clinical anxiety, depressive hopelessness, or 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.

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.

A clear understanding and appreciation of the self-protective nature of this woman's hostilities are necessary to create a therapeutic alliance. She likely has limited experience relating to others on a genuinely empathic level, while having that attitude reciprocated. Her experience of antagonism throughout her lifetime has gone from being absorbed inwardly to being projected outwardly with little deviation between these two extremes. Her initial discomfort with the more equitable dynamic inherent in therapeutic relationships may feel like a failure to connect to the therapist, but it is a necessary intermediate step on the road to a deeper trust. Equally imperative, is to guide this woman to become aware of her unusual emotional state in the immediate. Hostilities are likely to emerge and dissipate, possibly repeatedly, and she may attempt to arouse the therapist's ire through testing or caustic behaviors. A firm but open therapeutic stance, one that withholds judgment, is necessary to gradually build trust. Further, this approach to therapy will bring with it a receptivity to challenge and an understanding that this woman can meet his personal needs with means other than aggression.

A circumscribed focus is likely to be optimally suited for this woman. During alliance building, behavioral observation and experimentation with moderate changes may be fruitfully deployed to achieve greater consistency and interpersonal harmony in her social behavior. As interpersonal successes are met, cognitive confrontation may then be used to highlight obstructive and self-defeating expectations within her personal relations. While the deeply rooted character of these problems will likely impede the effectiveness of many therapeutic procedures, the more confrontational, incisively cognitive, and interpersonal therapy techniques (especially combined in a potentiated pairing) are most likely to be successful. Because these techniques evidence a more immediate, tangible benefit, they are more time-critical and reinforcing than attempting a thorough reconstruction of personality aimed at altering her deeper pathologies. In support of these more focal approaches presented in a firm but understanding milieu, family treatment might be considered to focus on the complex network of relationships that can sustain her personality style. Together with cognitive reframing procedures, it may prove to be among the most useful approaches to help her recognize the source of her own wounded and angry feelings and to appreciate how she subsequently provokes these feelings in others.

Not surprisingly, this woman may actively resist exploring her motives. While she is not naturally disposed to be an active and willing participant in therapy, the aforementioned conditions of the therapeutic alliance are likely to encourage her and a hybrid cognitive/interpersonal intervention is likely to reinforce her motivations to accept change. She may have submitted to therapy under pressure but, in time, she may learn to see the benefits of reframing her attitudes and the consequences for doing so. For example, reframing her perceptions to accept at least a measure of accountability for the turmoil in her life should help to counter the belief that her problems can always be traced to another person's stupidity, laziness, or hostility. When she finally accepts responsibility for some of her troubles, she need not feel defiance or resentment toward the therapist for helping to point this out.

A strong and consistent attitude should overcome this woman's desire to outwit the therapist by setting up situations to test the therapist's skills, to catch inconsistencies, to arouse ire, and, if possible, to belittle and humiliate the therapist. For the therapist, restraining the impulse to express a condemning attitude may, at times, present a challenge. Goal-directed in a circumscribed treatment program, the therapist will be more readily able to check any hostile feelings, keeping in mind that this woman's tendency to act out or vent hostility is not personal and not yet under control. Nevertheless, as matters progress, she may actively impede her progress toward conflict resolution and goal attainment, undoing what good she has previously achieved in treatment. A combination of cognitive and interpersonal techniques should be employed to counteract her contrary feelings and her inclination to retract her more kindly expectations of others, and to quickly rebuild the advances she and the therapist have managed to attain. A balance of professional authority and tolerance will be useful to diminish the probability that she will relapse or impulsively withdraw from treatment.

End of Report

ITEM RESPONSES

1: 1	2: 2	3: 2	4: 1	5: 1	6: 1	7: 2	8: 2	9: 2	10: 1
11: 1	12: 2	13: 2	14: 1	15: 1	16: 1	17: 1	18: 1	19: 1	20: 1
21: 2	22: 1	23: 2	24: 2	25: 1	26: 1	27: 2	28: 1	29: 2	30: 1
31: 2	32: 1	33: 1	34: 1	35: 1	36: 2	37: 1	38: 1	39: 1	40: 2
41: 2	42: 2	43: 1	44: 2	45: 1	46: 1	47: 1	48: 2	49: 2	50: 1
51: 1	52: 1	53: 1	54: 2	55: 2	56: 2	57: 2	58: 2	59: 2	60: 2
61: 2	62: 2	63: 1	64: 1	65: 1	66: 2	67: 1	68: 2	69: 2	70: 1
71: 1	72: 1	73: 2	74: 1	75: 2	76: 2	77: 1	78: 2	79: 1	80: 1
81: 2	82: 1	83: 1	84: 1	85: 2	86: 2	87: 1	88: 1	89: 2	90: 2
91: 2	92: 2	93: 1	94: 2	95: 2	96: 1	97: 1	98: 2	99: 2	100: 2
101: 1	102: 2	103: 2	104: 2	105: 2	106: 2	107: 2	108: 2	109: 1	110: 2
111: 1	112: 1	113: 2	114: 1	115: 2	116: 1	117: 2	118: 1	119: 2	120: 1
121: 2	122: 1	123: 1	124: 2	125: 1	126: 2	127: 2	128: 1	129: 1	130: 2
131: 1	132: 2	133: 2	134: 1	135: 2	136: 2	137: 1	138: 2	139: 1	140: 2
141: 2	142: 2	143: 2	144: 2	145: 2	146: 1	147: 1	148: 2	149: 2	150: 2
151: 1	152: 1	153: 2	154: 1	155: 1	156: 1	157: 2	158: 1	159: 2	160: 2
161: 2	162: 1	163: 2	164: 1	165: 2	166: 1	167: 1	168: 1	169: 1	170: 1
171: 2	172: 1	173: 2	174: 2	175: 1	176: 2	177: 2	178: 1	179: 1	180: 2
181: 2	182: 2	183: 1	184: 1	185: 1	186: 2	187: 1	188: 2	189: 2	190: 1
191: 1	192: 1	193: 1	194: 2	195: 2					