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M-PACI™  
Millon™ Pre-Adolescent Clinical Inventory  
Interpretive Report  
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Name: Sample Interpretive Report  
ID Number: 12345  
Age: 11  
Gender: Male  
Grade: 6th Grade  
Date Assessed: 06/19/2004



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## MILLON PRE-ADOLESCENT CLINICAL INVENTORY

RESPONSE VALIDITY INDICATORS

INVALIDITY SCORE: 0

RESPONSE NEGATIVITY RAW SCORE: 15

RESPONSE NEGATIVITY PERCENTILE SCORE: 40

CATEGORY	SCORE		PROFILE OF BR SCORES						SCALE	
	RAW	BR	0	60	70	80	90	100		
EMERGING PERSONALITY PATTERNS	1	9	55							CONFIDENT
	2	11	70							OUTGOING
	3	8	49							CONFORMING
	4	1	10							SUBMISSIVE
	5	4	33							INHIBITED
	6	16	90							UNRULY
	7	6	51							UNSTABLE
CURRENT CLINICAL SIGNS	A	0	0							ANXIETY/FEARS
	B	1	7							ATTENTION DEFICITS
	C	7	52							OBSESSIONS/COMPULSIONS
	D	14	88							CONDUCT PROBLEMS
	E	11	84							DISRUPTIVE BEHAVIORS
	F	0	0							DEPRESSIVE MOODS
	G	1	16							REALITY DISTORTIONS

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## INTERPRETIVE CONSIDERATIONS

The following interpretive report is based on normative data that were obtained from 9- to 12-year-olds who were being seen in professional treatment settings for family discomforts, academic problems, social difficulties, and/or emotional upsets. Exaggerated statements of severity may be erroneously reported for respondents who inappropriately took the M-PACI inventory for other than such clinical purposes. Further, owing to developmental fluctuations in emotion and behavior that are characteristic of this age group, the report must be considered a "snapshot" of this child's emerging and changeable psychological patterns.

Note that the report is based in part on psychological inferences in addition to empirical correlates with clinical judgment. It is therefore composed of probabilistic statements. It must be employed as only one aspect of a thorough clinical evaluation and should not be shown directly to either the child or his family without prudent consideration and clinical discretion.

The child who completed this M-PACI inventory is an 11-year-old boy. He is in the 6th grade at school.

## RESPONSE VALIDITY

This child received a score of 0 on the Invalidity scale. This means that he did not endorse any of the four items stating that he was not giving honest answers when completing the inventory. He probably understood and successfully followed the directions, understood the items, stayed focused on the task, and answered purposefully rather than randomly. In addition, he claimed to be answering truthfully.

This child's score on the Response Negativity scale is at the 40th percentile, placing it in the middle 50% of scores (i.e., the 25th through 75th percentile) obtained by the M-PACI clinical norms sample. This middle-range score suggests that it is unlikely that he grossly underreported or overreported problems when completing the inventory.

## EMERGING PERSONALITY PATTERNS

This section of the interpretive report pertains to those evolving and potentially enduring traits that underlie the personal and interpersonal difficulties of this pre-adolescent. It concentrates on his maladaptive methods of relating, behaving, thinking, and feeling that are developing and may note some typical symptoms that are characteristic of such children. Specific clinical signs identified by the M-PACI inventory will be described in the Current Clinical Signs section.

This M-PACI profile is characteristic of a pre-adolescent boy who is assertive and outspoken. Autonomy and self-determination are other prominent personality features. He is very independent-minded and projects a sense of confidence and boldness in his interactions with peers and authority figures. He can be brazen in his actions and unfettered by anxiety or a fear of consequences. He can be a challenge to manage, but trust and respect can temper this tendency.

Clinically, this profile suggests an often problematic and difficult boy who is characterized by unruliness, unpredictable moods, resentful irritability, conduct misbehavior, impulsivity, and the feeling of being cheated, misunderstood, and unappreciated. His assertive and bullying behavior contributes to an impulsive and quixotic emotionality. His pattern of negativism and unruliness is punctuated periodically by belligerent outbursts and intimidating acts.

He anticipates being demeaned by others and for this reason often behaves obstructively, thereby creating the expected derogation. He is deeply untrusting and alert to efforts that might undermine his self-determination and autonomy. His family relationships may be fraught with wrangles and antagonism, to which he may contribute a bitterly complaining and oppositional attitude. The struggle between feelings of resentment and expressions of anger and the conflict between submission and defiance permeate many aspects of his life. He may display an unpredictable and rapid succession of contradictory moods. Restless, aversive, disheartened, capricious, and erratic, he tends to be easily nettled, contrary, and offended by trifles. A low tolerance for frustration is notable as is his vacillation between being resentfully restrained and irrationally contentious. As a result, he may have already been stereotyped as a child who dampens the spirits of everyone, a pre-adolescent malcontent who demoralizes and obstructs himself and others.

He experiences conflicting impulses to act out and to turn his resentment inward. His sulking, rule-violating, blowing-hot-and-cold bullying behavior is self-defeating in that it induces others to react in a similarly inconsistent manner. As a consequence, he feels misunderstood and unappreciated and tends to be manipulatively defensive and suspicious. He fears displaying weakness, however, because he sees it as a concession that others will use maliciously. Unfortunately, his behavior sets in motion a self-fulfilling prophecy, creating unnecessary friction and thereby confirming and justifying his pattern of unruliness and impulsive hostility.

## **CURRENT CLINICAL SIGNS**

The features and dynamics of the following distinctive clinical signs are worthy of description and analysis. They may arise in response to external precipitants, but they may also reflect and accentuate aspects of the child's emerging personality patterns.

The one or two clinical symptom areas that appear to be most prominent based on the child's M-PACI scores are discussed in this section of the report. M-PACI results and/or other assessment data may indicate additional clinical signs that warrant attention.

There are strong indications that this boy displays pervasive conduct problems. Acting out aggressively is an extension of his generally unruly and negativistic lifestyle. Though angry and resentful, he may enjoy the superficial camaraderie of similarly rebellious companions. In addition to consonance with his overall rebellious and difficult lifestyle, bullying behaviors provide an outlet for a variety of revengeful attitudes and resentments such as anti-authority feelings, resistance to adhering to responsible social ideas, and rejection of family constraints and expectations.

This boy is often irritable, negative, and hostile. His disruptive actions not only help him unwind his tensions and undo his conflicts but also serve as a statement of resentful independence from the

constraints of social convention and expectations. In addition to freeing him from feelings of ambivalence about himself and others, impulsive acts liberate him from whatever remnants of guilt he may experience about discharging his less-charitable fantasies. Such defiant and hostile tendencies are undergirded and evident in the careless disregard he may express toward the consequences of his misbehavior.

## NOTEWORTHY RESPONSES

The child answered True to the following critical items. These responses suggest specific problem areas that the clinician may wish to investigate.

### Distressing Thoughts

- 64. I am bothered by thoughts that won't go away.
- 78. Sometimes a bad thought comes into my mind and I can't get rid of it.

### Post-Traumatic Stress

- 41. I keep thinking about something terrible that happened to me.

## TREATMENT CONSIDERATIONS

The precipitant for treatment with this child is probably situational (e.g., academic troubles, school conduct, family problems). He is unlikely to have sought therapy voluntarily, and he may be convinced that if he were just left alone he could work matters out on his own. Treatment is probably inspired by a series of school difficulties or achievement failures. For this occasionally intimidating child, complaints are likely to take the form of feelings of irritability and restlessness. To succeed in his disinclination to be frank with authority figures, he may wander from one superficial topic to another. This inclination should be monitored and prevented. Moreover, contact with family members may be advisable because they may report matters quite differently than he does. To ensure that he takes discussions seriously, he may have to be confronted directly with evidence of his misbehavior. Treatment may be best geared to short-term goals, such as reestablishing his psychic controls and strengthening previously appropriate coping behavior. In general, efforts with this child are best directed toward building controls rather than insights, toward the here-and-now rather than the past, and toward teaching him ways to sustain relationships cooperatively rather than with disruptions and intimidation.

Power struggles between parent and child are another worrisome pattern with problematic consequences, especially if it leads the parents to become less nurturing and empathic. The child may state that his parents say they love him, but they "hate" everything that he does. In such a case, the parents will help the emotionally ambivalent child only by becoming sensitive to his insecurities and vulnerabilities. This child is unable to safely convey his deep needs for comfort and security; defiance is his defense against continued loss. It is crucial for the parents to get around his defiance and confusion and somehow regain his trust and confidence. They must be helped to provide a consistent measure of compassion and empathy in spite of his obstructiveness and negativism. This is no easy task, because he will be quite suspicious of initial parental efforts to be comforting. Progress calls for moving slowly and in a soothing manner.

The parents should also pay special attention to counteracting their child's tendency toward bullying behaviors. Parent and teacher meetings should be undertaken to ask for input from both regarding the child's tendency to engage in intimidating actions, especially with younger siblings and peers. He should be confronted about his unacceptable actions. His capacity for empathy and social care should be appraised. Role-reversal sessions may be helpful to teach him how his victims feel. Having him spell out the feelings he experiences may help reinforce an awareness of the discomfort he creates in others with his own unkind behaviors. Important as well are procedures by which he can identify and learn prosocial means of attaining his goals. Thus, he may gain a measure of leadership through acts of firm assertiveness rather than disruptive bullying and intimidation. Family sessions may prove helpful in acquiring conflict resolution methods, not only for the child but often for other family members. Where available in school settings, assignment to a social skills training group should also help in teaching respect and social consideration.

Rarely does he experience guilt or accept blame for the turmoil he may cause. To him, a problem can always be traced to another person's stupidity, laziness, weakness, or hostility. Even when he may accept a measure of responsibility for his difficulties, he may resent the therapist for tricking him into admitting it. Not uncommonly, he may challenge and seek to outwit the therapist. He may set up situations to test the therapist's skills, to catch inconsistencies, to arouse ire, and, if possible, to belittle and humiliate. Restraining impulses to express condemning attitudes will not be easy for the therapist, who will have to expend great effort to check counter-hostile feelings.

The therapist must be ready not only to see things from this child's point of view but also seek to convey a sense of trust and to create a feeling of alliance. This building of rapport must not be interpreted as a sign of the therapist's capitulation to the child's bluff and arrogance. Therefore, professional firmness and authority mixed with tolerance for his less attractive traits must be maintained. By building an image of being a fair-minded and strong authority figure, the therapist may encourage him to change his expectations. Through quiet and thoughtful comments, the therapist may provide a model for learning the mix of power, reason, and fairness.

Less confrontive cognitive approaches may provide this child with opportunities to vent his anger; once drained of venom, he may be led to explore his habitual feelings and attitudes and be guided into less destructive perceptions and outlets than before. As far as group methods are concerned, this child may disrupt therapeutic functions. On the other hand, he may become a useful catalyst for group interaction and gain useful insights and constructive social skills.

## ITEM RESPONSES

1: 2	2: 2	3: 1	4: 1	5: 2	6: 2	7: 2	8: 2	9: 1	10: 1
11: 1	12: 2	13: 2	14: 1	15: 1	16: 1	17: 2	18: 1	19: 2	20: 2
21: 1	22: 2	23: 2	24: 2	25: 1	26: 2	27: 2	28: 1	29: 2	30: 2
31: /	32: 1	33: 2	34: 1	35: 1	36: 2	37: 2	38: 1	39: 2	40: 2
41: 1	42: 1	43: 2	44: 1	45: 1	46: 2	47: 2	48: 2	49: 2	50: 2
51: 2	52: 2	53: 1	54: 1	55: 1	56: 2	57: 1	58: 2	59: 1	60: 1
61: 2	62: 2	63: 1	64: 1	65: 2	66: 2	67: 1	68: 1	69: 2	70: 2
71: 2	72: 2	73: 1	74: 2	75: 2	76: 2	77: 2	78: 1	79: 2	80: 2
81: 2	82: /	83: 1	84: 2	85: 2	86: 2	87: 2	88: 2	89: 1	90: 1
91: 2	92: 2	93: 1	94: 2	95: 2	96: 2	97: 2			

**End of Report**