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Millon Clinical Multiaxial Inventory-IV (MCMI-IV) Profile Patterns and Scale Score Correlates for Jail Inmates Referred for Mental Health Services

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Abstract

Establishing the Utility of the Millon Clinical Multiaxial Inventory-IV (MCMI-IV) with Inmates Referred for Jail Mental Health Services

by

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Personality assessment measures have been heavily used and researched with criminal offender populations in the realms of clinical, forensic, and correctional psychology for reasons including assessing reoffending risk, informing predictions regarding future behavior, and treatment planning. The Millon Clinical Multiaxial Inventory (MCMI) features among the personality assessment measures widely used in evaluating criminal offenders. This current study compromised of adults male inmates (N=95) incarcerated in Brevard County, Florida examined scores from the recently released Millon Clinical Multiaxial Inventory-Fourth Edition (MCMI-IV). The study's goals included (a) providing reference data based on a sample of jail inmates receiving mental health services, (b) establishing correlates of MCMI-IV scale scores using variables from an institutional mental health screener, and (c) examining scale score differences between violent and non-violent offenders. Biserial correlations were computed to establish correlates of the MCMI-IV scale scores with substance use and suicide-related variables on the mental health screener with the intent of expanding the current MCMI-IV scale descriptors. Overall, there were no significant correlates found with the substance use correlates of the MCMI-IV scales and some inverse correlations with suicide-related risk

factors of MCMI-IV scales. Multivariate and univariate analyses comparing the scores of violent and nonviolent offenders showed no significant differences for the primary MCMI-IV scales. However, some significant differences were found when analyzing the Grossman facet scales. Contributions and limitations of these findings, as well as future research directions, are discussed.

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Introduction

As of December 2016, the United States Department of Justice reported there were 6,676,200 persons supervised by a United States adult correctional system, which includes local jails, prisons, and community supervisions (i.e. probation and parole) (Zeng, 2018). Specifically, there were approximately 2,162,400 adult inmates being housed and supervised in a U.S. correctional facility, according to the Bureau of Justice Statistics (BJS; 2016). Local jails accounted for 740,700 of the overall incarcerated inmates while federal prisons housed approximately 1,505,400 inmates. The number of inmates incarcerated in local jail facilities increased from 621,100 in 2000 to 740,700 in 2016 (Kaeble & Cowhig, 2018). Additionally, the number of inmates housed in local jail facilities increased 1.8% within the year of 2016 compared to the 1.4% decline in inmates housed in prison facilities within the same year span.

In 2016, 85.5% of the inmate population in local jails were men and 14.5% were women (Zeng, 2018). Additionally, inmates housed in local jails were comprised of the following ethnicities: 48.1% Whites, 35.8% Blacks/African American, 14.8% Hispanic/Latinos, 1.4% American Indian or Alaska Native, 0.7% Asian, Native Hawaiian, or Other Pacific Islander, and 0.2% of Two or more races. The data also indicates that 69.7% of the inmates were convicted of felonies, 25.4% convicted of misdemeanors, and 4.9% convictions were classified as "other" (Zeng, 2018).

According to BJS (2016) data, Florida ranked as the tenth highest in incarcerated individuals in the nation, surpassing the national average. There were an estimated 52,430 inmates housed in Florida's local jails in 2016. Brevard County, a county located in central Florida, was the home of 568,919 residents in 2017. Within the same year, the

Brevard County Detention Center had an average daily population of 1,679 inmates, yielding a 3.0% incarceration rate. Among the Brevard County Detention Center inmate population, 76.1% of the inmates were being housed under pre-trial conditions and had not yet been convicted. Demographic data obtained two years prior, in 2015, indicated the jail was comprised of the following ethnicities: 2 Asian / Pacific Islanders, 482 Blacks and African Americans, 8 Latinos, and 1,046 Whites. Additionally, the jail supervised approximately 288 female and 1,250 male inmates. There were 18, 945 Brevard County Detention Center overall admissions in 2017, a 7.7% increase from the 17, 597 admissions in 2016. Inmates were serving an average stay of 32.8 days of incarceration with a 6.0% turnover rate. The Florida Department of Law Enforcement (2018) maintains records of seven index offenses that result in incarceration in the Brevard County Detention Center. These include murder, sexual offenses, robbery, aggravated assault, burglary, larceny, and motor vehicle theft offenses (Florida Department of Law Enforcement, 2018).

In the United States, a lawful arrest is made once an officer has established probable cause to believe the suspect in question has committed an unlawful act, as outlined under the U.S. Constitution's Fourth Amendment (Bergman & Berman, 2013). After an arrest is made, the suspect typically undergoes a booking process at a nearby jail where individuals are housed under supervision for minor offenses (e.g. assault or drug offenses), to await trial, or to prepare for their transfer to prison. At the time of booking, a standard procedure is followed with each inmate, which includes a physical health and mental health screening to determine if there needs to be a medical or mental health referral made for further assessment (Bergman & Berman, 2013).

The Bureau of Jail Statistics reported that 64% of all local jail inmates experience symptoms of serious mental illness while incarcerated (National Alliance on Mental Illness, 2006). Specifically, mental health concerns have impacted approximately 75% of female and 63% of male inmates. Mentally ill inmates remain incarcerated for a longer period of time compared to their peers who do not experience mental health concerns. Furthermore, studies have demonstrated that there are more mentally ill individuals being treated and housed in a correctional setting than in a psychiatric hospital (Torrey, 2014; Torrey, 2010). Inmates suffering from a mental illness housed in the Orange County, Florida jail remain incarcerated for approximately 51 days on average compared to the average 26-day stay for their peers without symptoms of a serious mental illness (Council of State Governments, 2002). One primary contributing factor for the extended stay of mentally ill inmates is their inability to uphold the correctional setting rules and regulations. Mentally ill inmates have been found to be twice as likely to incur disciplinary infractions while incarcerated compared to those without a mental defect (Fuller et al., 2016). Suicide has become another rising concern for inmates in more recent years and has consistently served as the leading cause of death since 2000. In 2013, there were 967 jail inmate deaths while under correctional supervision, of which 34% of the deaths were determined to be incidences of suicide. According to the BJS (2016) report, there were approximately 50 suicides per 100,000 inmates housed in a local jail, which had been the highest suicide rate observed since 2000. Within a single year, suicide rates in jails increased 14% from 2012 to 2013. Studies have estimated approximately half of all suicides are committed by mentally ill inmates (Goss et al., 2002).

Studies designed to examine the prevalence rates of mental illness inside U.S. jail settings have found variable results. The U.S. Bureau of Justice Statistics (1999) estimated that 16.3% of inmates have been hospitalized for mental health concerns in their lifetime or have reported a mental health condition. A worldwide systematic review conducted in 2002 revealed that approximately 10.2% male and 14.1% female inmates have been diagnosed with Major Depression (Senior et al., 2013; Fazel & Seewald, 2012). Likewise, 3.6% male and 3.9% of female inmates have been diagnosed with a psychotic disorder (Fazel & Seewald, 2012). Conversely, personality disorder diagnoses have been shown to have variable ratios in prevalence rates studies, ranging from 7-10% (Gunn, Maden & Swinton, 1991; Birmingham, Mason, & Grubin, 1996). However, although there is significant variability in prevalence rate reporting, personality disorders are nonetheless present within the correctional setting.

The presence of personality disorder and other mental health diagnoses suggest that further personality research is needed for identifying such disorders within the inmate population. Diagnostic instruments, such as personality assessments, have been widely used to identify and clarify diagnoses (Birmingham et al., 1996). Use of standardized personality measures provides important information not otherwise available, helps to improve the quality of the inferences made about offenders, and facilitates their management within the criminal justice system (Hemphill & Hart, 2001). There is a wide array of reliable and valid personality assessment measures that undergo ongoing updates and revisions. Among the more recently updated personality assessments is the Millon Clinical Multiaxial Inventory-IV (MCMI-IV), which is the focus of the current study.

Review of the Literature

Personality

William McDougall (1932) characterized *personality* as a construct composed of five distinguishable factors, including intellect, character, temperament, disposition, and temper; personality is seen as "complex and comprises many variables" (as cited in Digman, 1990, p.15). His contribution would be the beginnings of organizing the concept of personality into a comprehensible construction.

In more recent psychological literature, *personality* has been broadly defined in terms of people's characteristic patterns of thinking, acting, and behaving (Pervin & John, 1999). This broad definition would suggest that personality is stable, given its pattern-like nature. Another definition of personality offered by Cohen and Swerdlik (2010) is "an individual's unique constellation of psychological traits and states," which include aspects of individualistic values, attitudes, interests, acculturation, worldview, personal identity, sense of humor, and cognitive and behavior styles (p. 379). A *personality trait* is defined as a distinguishable, relatively long-lasting pattern that differentiates individuals from one another (Guilford, 1959). Personality traits have the tendency to be largely consistent, although certain personality traits may be overtly manifested in certain contexts or situations and not others. In contrast, *personality states* are displayed short-lived behavioral predispositions that are primarily situationally driven. Therefore, personality states may appear and dissipate as the situation changes (Chaplin et al., 1988).

Personality Structure. The development of temperament and personality are often found in research to have an interdependent relationship, as the former lays the foundation for the structuring of the latter. Historically, the primary focus of the developmental psychologist has been to identify temperament traits and behavioral patterns present in early development, whereas the work of personality researchers has been grounded on the broader study of individual differences among adults in regards to thought, behavior, and emotional patterns. Temperament has been characterized by "narrow, low-level traits" (Caspi, Roberts, & Shiner, 2005, p. 454), which provide context and understanding for the structure of the adult personality, given the childhood antecedents (Caspi et al., 2005; McCrae et al., 2000). Both the development of temperament and structuring of personality are also found to be moderately influenced by genetics (Bouchard & Loehlin, 2001), as well as environmental experiences (Emde & Hewitt, 2001). Moreover, emotional expressions, such as positive and negative emotions, are fundamental for many temperament and personality traits (Rothbart et al., 2000; Watson, 2000).

During early stages of infancy, children develop primary emotions such as joy, sadness, shame, guilt, pride, anger, fear, and empathy, by approximately age three (Eisenberg, 2000; Lewis, 2000). Concurrently, children at this age are undergoing major developments in their motor skills, cognition, and language abilities. Such early developments, and the individual differences displayed given the level of development in each aforementioned skill, serve as a foundation for the structuring of temperament and personality that will endure across the lifespan (Caspi et al., 2005). Common models of childhood temperament have examined and included six primary traits: activity level,

ability to be soothed, attention span capabilities, presence of positive emotions and desire to seek pleasure, adaptability to new situations, and experiences with stress, anger, and frustration (Lemery et al., 1999, Rothbart & Bates, 1998).

In relatively recent research, researchers have conceptualized and reached an increased consensus on understanding adult personality as a higher-order structure. One of the most commonly referred to models is the Five-Factor Model. From this viewpoint, adult personality began to be understood in a five-factor model structure, which included: I. Extraversion/Introversion (or Surgency); II. Friendliness/hostility (or Agreeableness); III. Conscientiousness (or Will); IV. Neuroticism/emotional stability (or Emotional Stability); and V. Intellect (or Openness) (Caspi et al., 2005; Digman, 1990). Extraversion is defined by active engagement with one's surroundings in a dominant, expressive, and outgoing manner. The second factor, Agreeableness, is seen in individuals who are generally cooperative, generous, and empathetic. Individuals who are careful, planful, responsible, and have the capability for effortful attention are viewed as Conscientious. Neuroticism is often displayed through heightened anxiety and increased vulnerability to stress. Finally, Openness to Experience is marked by features of being imaginative, quick to learn, and insightfulness (Caspi et al., 2005). Additionally, lower-order personality traits are included within higher-order personality traits, such as sociability dominance corresponding with extraversion. These lower-order traits have been found to be useful in examining behavioral outcomes (Paunonen & Ashton, 2001).

Personality Dysfunction. Personality disorders are the results of dysfunction that arise when personality characteristics and traits become rigid and are used in maladaptive ways (Pervin & John, 1999). A *personality disorder* has been broadly defined as an

enduring pattern of inner experience and behavior that deviates from socially appropriate behaviors, adversely impacting the individual's thought processes, emotional displays, interactions with others, and impulse control (American Psychiatric Association, 2000). An individual's personality, or set of characteristics and traits, develops into a personality disorder when the dysfunction in his or her personality traits results in impairments in social, occupational, and/or other important functions of the individual's life.

Various personality theories and trait theories have emerged over time in the field of clinical psychology to explain personality and personality dysfunction. Such theories seek to explain how characteristics of an individual are organized in relation to one another and their degree of abnormality, their determinants and influences, and the reasons for behavioral manifestation of such personality traits and characteristics (Pervin & John, 1999). Theorists have often rooted their theories on personality in the context of genetic and environmental factors as well as psychological factors. For instance, the diathesis-stress model has been used to explain the predispositions, as well as the situational triggers, that lead to the development of a personality disorder (Paris, 2004). This model suggests that the interplay of an individual's temperament, which is the individual's behavioral disposition present at birth, and the individual's personality traits, which are shaped by his or her temperament and life experiences, often determines the expression of a personality disorder (Strack, 2005). Some theorists, such as Theodore Millon, have developed personality theories through conceptualizing and detailing personality as a construct that exists on a continuum, ranging from personality styles to personality disorders, that are in alignment with the diagnostic criteria outlined in various editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Dysfunctional personality traits are often the focus of clinical psychology practice. One of the primary purposes of the field of clinical psychology is to gain clinical knowledge in identifying, understanding, preventing and relieving psychological dysfunction (Shakow, 1976). Thus, the development of personality assessment instruments arose to aid measuring personality traits and their degree of dysfunction. *Personality assessment* is defined as the evaluation of personality traits, states, and individualistic components, such as attitudes and interests (Cohen & Swerdlik, 2010). There are a multitude of methods by which personality can be measured through objective, projective, and behavioral assessment. Thus, methods of personality assessment can range from performance-based measures to self-report questionnaires. The present research is centered on self-report methods of personality assessment. The commonly used objective personality measures and their functions are discussed in future sections.

Personality Assessment Applications in Forensic and Correctional Psychology

Forensic psychology has been identified as a specialty area of the larger field of clinical psychology. Forensic psychology has been broadly defined as the application of psychology to any legal matters, and more narrowly characterized as a field comprised of clinical psychologists engaging with legal systems for the purpose of fulfilling roles as examiners, consultants, and treatment providers. At its core, forensic psychology involves the interaction between psychology and the legal process (Brigham, 1999; Huss, 2009). The Forensic Specialty Council, one of the committees within the American Psychological Association (APA) committee for specialties and proficiencies, provided the following description of forensic psychology:

> "Forensic psychology is the professional practice by psychologists within the areas of clinical psychology, counseling psychology, school psychology or another specialty recognized by the [APA], when they are engaged as experts and represent themselves as such, in an activity primarily intended to provide professional psychology expertise in the judicial system" (Forensic Specialty Council, 2008).

The APA's Specialty Guidelines for Forensic Psychology describe the specialty as a "professional practice by any psychologist working within any sub-discipline of psychology (e.g., clinical, developmental, social, and cognitive) when applying the scientific, technical, or specialized knowledge of psychology to the law to assist in addressing legal, contractual, and administrative matters" (APA, 2013, p.7).

The field of forensic psychology has various applications, including assessing violence risk. When conducting violence risk assessments, forensic psychologists are, first, charged with assessing and developing a clinical and/or actuarial prediction about an individual's risk level, given a particular context or situation (Mossman, 1994). This typically includes assessing for additional risk factors that would likely lead the offender to an increased level of dangerousness or chance of reoffending. Commonly examined risk factors include history of violence at various stages in development, relationships, evidence of antisocial behavior at various ages, employment, substance use, major mental disorder, personality disorder, traumatic experiences, and violent attitudes. Secondly, forensic psychologists are to determine the contexts in which an offender's risk likely increases or decreases. The goal is to prevent future offending and to develop a plan for prevention and intervention, which is the main concern for management. A

comprehensive clinical evaluation, including forensic and personality assessment tools, is often used to accurately identify such level of risk (Otto & Weiner, 2014).

Distinguishing Forensic and Correctional Psychology. Historically, forensic psychology and correctional psychology have not been differentiated but rather viewed as a single specialty field, defined as "psychology and the legal system" or "psychologists in criminal justice settings" (Brodsky, 1973; Monahan, 1980; Tapp, 1976). However, as this field of psychological application continued to evolve, forensic and correctional psychology branched into separate, but related, specialties. Correctional psychology is a specialized division of forensic psychology that focuses primarily on the application of psychology to jails, prisons, and other correctional settings (Magaletta, Patry, Dietz, & Ax, 2007). A more specific definition of correctional psychology states it is "a subfield of psychology in which basic and applied psychological science or scientifically oriented professional practice is applied to the justice system to inform the classification, treatment, and management of offenders to reduce risk and improve public safety" (Neal, 2018, p. 652).

Correctional psychologists are found to often engage in professional activities such as identifying and treating psychopathology, promoting suicide prevention, and ensuring safety among inmates (Magaletta et al., 2007). Other tasks might include conducting research to examine the psychological effects of incarceration, providing therapeutic treatment and crisis intervention, and to provide assessment services to better inform offender treatment, management, and post-release decision-making (Neal, 2018; Otto & Hellbrun, 2002). Therefore, forensic psychology primarily works to aid and

answer adjudication-relevant questions, whereas correctional psychology aims to conduct research on offender risk and improve public safety (Neal, 2018).

In the correctional setting, personality assessment has been used primarily as a routine screener for psychological disturbances at the time of admission, response styles and malingering, and to assess risk of the offenders (Archer, 2013; Edens, Cruise, & Buffington-Vollum, 2001). Research in correctional settings have also aimed to highlight commonalities within subgroups of offenders, such as mentally ill inmates, that differentiate one particular subgroup of offenders from another.

Characteristics of Mentally Ill Inmates. A national research study conducted by James, Glaze, and the United States Bureau of Justice Statistics (2006) examined 705, 600 inmates located in State prisons, 78,800 housed in Federal prisons, and 479, 900 housed in local jails. Specifically within the local jail inmate sample, their research showed inmates incarcerated in local jails who reported having a mental health problem are more likely to report other risks when compared to their counterparts without a mental health problem. Some risk factors identified in research have included substance use and abuse, prior criminal record, poor familial history, problems with compliance with facility rules, and vulnerability while incarcerated. Of the inmates incarcerated in a local jail facility, 76% of inmates with mental health problems also reported substance dependence or abuse, whereas 53% of inmates without a mental health problem reported having a substance dependence or abuse problem. Approximately 62% of local jail inmates with a mental illness indicated using an illicit substance one month prior to arrest, compared to 42% of those without a mental health problem. Forty-four percent of inmates who experience mental health problems reported a current or past violent offense

history and 26% reported three or more prior incarcerations, compared to 36% and 20% of inmates, respectively, without mental health problems. In regards to family background, 17% of mentally ill inmates experienced homelessness in a year prior to arrest, 24% experienced past physical or sexual abuse, and 37% reported their parents abused alcohol or drugs. Local jail inmates without mental health problems reported lowered rates of homelessness history within the year of arrest, past physical and sexual abuse, and experience with parents who abused alcohol or drugs – 9%, 8%, and 19%, respectively. While incarcerated, 19% of mentally ill inmates (vs. 9% of inmates without mental health problems) received disciplinary reports for violating institutional regulations, and 8% of those inmates (vs. 2%) had engaged in a form of verbal or physical assault. In addition to an increase in facility violations while incarcerated, inmates with mental health concerns were also more likely to report an increase in safety and vulnerability risk compared to inmates without mental health problems; nine percent of mentally ill inmates reported being physically injured in a fight since admission compared to 3% of inmates without mental health problems (James et al., 2006).

Among jail inmates, mental health inmates with a mental health problem (76.4%) were more likely to report any form of drug or alcohol abuse or dependence than inmates without mental health concerns (53.2%). Specifically, 56.3% mentally ill inmates were found to have any form of alcohol or drug dependence and 20.1% were found to engage in solely illicit substance or alcohol abuse. Moreover, there was lower variability in mentally ill inmates who reported alcohol dependence (29%) and mentally ill inmates who reported alcohol abuse only (22.4%). However, greater variability was identified for non-mentally ill inmates – 11.8% alcohol dependence and 22.8% alcohol abuse only.

Notably, the opposite trend was detected in regards to illicit drug use. Forty-six percent of mentally ill inmates reported drug dependence and 17.3% reported drug abuse only, whereas, inmates without mental health had a lower variability, 17.6% and 18.4%, respectively (James et al., 2006).

In regards to criminal record history, mental health status illuminated moderate differences with respect to types of offenses, prior sentencing, violent recidivism, and nonviolent recidivism. Among violent offenses (i.e., homicide, robbery, and sexual assault), inmates with mental health problems (26.5%) were more likely to be admitted with violent offenses than inmates without mental health concerns (23.7%). Similarly, inmates with a mental illness (26.9%) were more likely to be charged with property offenses (i.e. burglary, larceny/theft, and fraud) in comparison to their counterparts (19.7%). However, inmates without mental health problems were more likely to commit drug offenses (i.e. possession and trafficking) and public-order offenses (i.e. weapons, DWI/DUI) – 27% and 29.3%, respectively – compared to mentally ill inmates – 23.4% and 22.6%, respectively. Additionally, inmates with mental health concerns were found to have a lower rate of no prior sentences on the criminal record (34.9%) and nonviolent recidivism (33.2%), but had a higher rate of violent recidivism (31.9%) when compared to inmates without mental illness in regards to no prior sentencing on their criminal record (43.3%), nonviolent recidivism (34.3%), and violent recidivism (22.4%) (James et al., 2006).

Other external characteristics, such as poor childhood experiences and familial history of incarcerations, have been disproportionally conveyed by local jail inmates with an identified mental health problem when compared to inmates without mental health

concerns. For instance, approximately 43% of inmates with mental health problems received public assistance at least once in their childhood compared to approximately 30% of their counterparts. Approximately 15% of mentally ill inmates had lived in a foster home, agency setting, or in an institution, whereas 6% of psychologically healthy inmates experienced similar settings. Even when placed in a standard home setting, mental health inmates continued to report familial disadvantages at a higher rate than those without mental health symptoms. While inside the home, mental health inmates reported the following: 40.5% living with both parents, 45.4% living in a single-parent household, and 12% living with someone else. On the contrary, inmates housed in a local jail setting without mental health symptoms reported the following: 49.1% living with both parents, 40.4% living in a single parent household, and 9.4% living with someone else. Likewise, 52.1% of mentally ill inmates, compared to only 36.2% of inmates without mental health problems, reported having a family member incarcerated at a given point (James et al., 2006).

A 2002 survey of this sample of jail inmates, which included a structured clinical interview, assessed for symptoms of major depression, mania, and psychosis within 12 months prior to evaluation or since admission. Commonly reported symptoms of depression and mania were as follows: persistent sad, numb, or empty mood (39.6%); loss of interest or pleasure in activities (36.4%); increased or decreased appetite (42.8%); insomnia or hypersomnia (49.2%), psychomotor agitation or retardation (46.2%); feelings of worthlessness or excessive guilt (43.0%); diminished ability to concentrate or think (34.1%); ever attempted suicide (12.9%); persistent anger or irritability (49.4%); and increased/decreased interest in sexual activities (29.5%). Conversely, approximately 24%

of inmates housed in local jails, 15% of inmates housed in state prison, and 10% of inmates housed in federal prisons reported experiencing at least one symptom of a psychotic disorder. Among those experiencing symptoms of a psychotic disorder, 17.5% of inmates reported delusions, 13.7% reported hallucinations, and 7.2% of the inmates reported experiencing delusions and hallucinations in the 12-month period preceding the survey or since their jail admission (James et al., 2006).

With respect to mental health treatment, 42.7% of inmates housed in local jail units who reported experiencing mental health problem reported a history of having received mental health treatment. This includes the following encounters: an overnight hospital stay (18%), use of prescribed medications (32.7%), and experience with professional mental health therapy (31.1%). Within the same sample, 22.6% of inmates reported having received treatment within the year prior to arrest (i.e., an overnight stay in hospital (6.6%), used prescribed medications (19.9%), had been on prescribed medication at the time of arrest (12.3%), and had experience with professional mental health therapy (12.3%)). In regards to after care upon release from jail, 17.5% of mentally ill inmates indicated they received treatment after admission, including an overnight stay at the hospital (2.2%), use of prescribed medications (14.8%), and having experience with a mental health professional for therapy due to a mental or emotional problem (7.3%). Generally, the proportion of local jail inmates with a mental health problem who have received mental health treatment since admission (11%) has remained consistent from 1996 to 2002 (James et al., 2006).

Personality Assessment Measures

The primary contributions of personality assessment in the realm of clinical psychology has been to assist in accurate diagnosing, to guide therapeutic interventions and approaches, and to inform predictions of behavior in various contexts (e.g., educational, correctional; Wiggins, 2003). In forensic psychology, personality assessments are a means to inform forensically-relevant decisions, determine institutional risk classifications, and assist in mental health treatment (Wilkinson-Ryan & Westen, 2000). The most widely used objective personality tests in clinical and forensic psychology include the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) and Minnesota Multiphasic Inventory-2- Restructured Form (MMPI-2-RF), Personality Assessment Inventory (PAI), and the Millon Clinical Multiaxial Inventory, currently in its fourth edition (MCMI-IV). This section provides an overview of the first three measures. The MCMI-IV, which was the focus of the current study, is discussed in greater detail in the next section.

According to survey data provided by Borum and Grisso (1995) regarding psychodiagnostic test usage of forensic psychologists, forensic psychologists reported using the MMPI/MMPI-2, PAI, and MCMI 94%, 6%, and 32% of the time, respectively, in criminal responsibility evaluations. Furthermore, 42% of the surveyed forensic psychologists reported using an objective personality test "almost always" in competency to stand trial evaluations. Objective personality measures were disproportionately reportedly as being used at a higher frequency compared to intellectual/cognitive tests

(25%), projective personality tests (9%), and neuropsychological tests (11%) (Borum & Grisso, 1995).

Originating in 1943, the Minnesota Multiphasic Personality Inventory (MMPI) has evolved into the most widely used and researched personality assessment instrument (MMPI; Hathaway & McKinley, 1943). The MMPI is comprised of validity scales to detect aberrations in response styles, clinical scales and subscales assessing internalizing and externalizing personality characteristics, content scales assessing problem areas such as anxiety, depression, and poor treatment response, and a multitude of research-derived supplementary scales– all of which were designed to comprehensively examine an individual's personality structure and psychological disturbance. Hathaway and McKinley derived the items from considering the major psychiatric diagnoses during the time of test development. The implemented empirical keying approach allowed for items to load under particular scales if heavily endorsed in such a way that differentiated a specific diagnostic group (e.g. depressed patients) from the non-psychiatric group. Approximately four decades after its release, the MMPI underwent re-standardization to provide a contemporary, ethnically diverse and nationally represented normative sample and achieve improvements in items, resulting in the release of the MMPI-2 in 1989. The purpose and utility of the MMPI-2 remained the same as that of the original version of the test (Greene, 1991).

The MMPI-2 has established utility in various clinical, mental health, employment, and forensic settings. The instrument has been useful in clinical settings for assisting in formulating diagnostic impressions based on the degree of psychopathologic symptom endorsement and maladjustment seen in the test profile. Psychology

consultations in the medical field have often included conducting MMPI-2 assessment as a means to inform how patients are likely to respond to medical treatment and their predicted level of adjustment pre- and post-operation. Likewise, employers have incorporated MMPI-2 testing to assess for psychological dysfunctions in workers seeking to obtain sensitive and vulnerable job placements that may ultimately impact their safety or the safety of the community.

In the realm of forensic psychology, the MMPI-2 have been used to assess criminals' personality patterns in order to more accurately predict the likelihood and severity of expected future deviant behaviors. National survey data have shown the MMPI-2 is the most widely used personality instrument in forensic settings (Archer et al., 2013; Lees-Haley & Lees-Haley, 1992) and has been a predominant personality assessment tool worldwide in the area of forensics (Martin, Allan, & Allan, 2001). The MMPI-2 has also become an integral part of forensic assessment, meeting the Daubert standard, a rule of evidence regarding the admissibility for expert testimony in the courtroom setting. An empirically-derived offender classification system was developed using the MMPI, known as the Megargee Inmate Typology. The typology includes ten identified clusters (*Able, Baker, Charlie, Delta, Easy, Foxtrot, George, How, Item, and Jupiter*), which were intended to serve as a guide for describing the offender group and to assist in formulating proper management and treatment care (Megargee, 1997). Empirical studies demonstrating the utility of Megargee's classification system are limited. However, one researcher reported a 46% decrease in assaults after utilizing the typology to guide housing assignments (Bohn, 1979). Other researchers who have examined MMPI-2 profiles in correctional settings have also found commonalities in personality

patterns, particularly for predicting juvenile delinquency according to Scale 4 (Psychopathic Deviate) profile elevations (Hathaway & Monachesi, 1953; Hathaway & Monachesi, 1957).

The Minnesota Multiphasic Personality Inventory-2 Restructured Form (MMPI-2-RF; Ben-Porath & Tellegen, 2008) is a substantially restructured version comprised of 338 items. The original Clinical Scales developed for the original MMPI and maintained in the MMPI-2 have been restructured into a set of nine Restructured Clinical (RC) Scales (MMPI-2-RF; Tellegen et al., 2003; Ben-Porath & Tellegen, 2008). An additional 33 scales and 9 validity scales accompany the RC scales on the MMPI-2-RF to ensure reliability and validity of constructs that were originally assessed with the MMPI-2 item pool (Archer, 2013). Furthermore, in light of the Civil Rights Act of 1991 prohibiting gender and racial demographics from being considered in the employment process, the MMPI-RF norms are non-gendered, achieved by combining the scores of men and women in the MMPI-2 normative sample (Butcher, 2006).

The MMPI-2-RF has been implemented in clinical and nonclinical settings, including psychodiagnostic-focused assessments, psychological assessment of medical patients, and forensic-focused research and assessments. In relation to psychodiagnostic-focused assessment, the MMPI-2-RF has been used in investigation studies of combat veterans assessing posttraumatic stress disorder (PTSD) and mild traumatic brain injuries (mTBI). Additionally, the MMPI-2-RF has been used in preoperative psychological assessment procedures for patients undergoing spine surgery (Block, Ben-Porath & Marek, 2012) as well as differentiating depressed non-depressed patients contending with chronic pain (McCord & Derup, 2011). In forensic studies, the MMPI-RF has been used

to investigate the construct validity of the measure in regards to psychopathy in pre-trial criminal defendants, suggesting that the RC Scale, Antisocial Behavior (RC4), was the best predictor of psychopathy (Sellbom et al., 2012). Further research has been conducted in the realm of child custody litigations and parental fitness evaluations using the MMPI-2-RF (Archer et al., 2012; Pinsoneault & Ezzo, 2012; Stredny et al., 2006). Additionally, the instrument has been found to be useful in forensic assessments in assessing the severity of an individual's psychological dysfunction, overall personality characteristics, and general test-taking approach to the assessment tool, which may inform over- or under-reporting of problems by examinees.

Another commonly used personality assessment tool is the Personality Assessment Inventory (PAI; Morey 1991). The PAI was designed to extensively assess personality and provide information regarding psychological functioning and psychopathology. The PAI is comprised of 344 self-report items organized in four validity scales, 11 clinical scales, 5 treatment scales, and 2 interpersonal scales (PAI; Morey, 1991). The structure of the PAI was intended to include a wide variety of personality constructs while also assessing depth within each construct through multiple response options that assess for severity (Archer, 2013).

The PAI has been applied in comprehensive forensic assessments due to its ability to assess for response style, clinical disorders, substance abuse, risk of violence and suicide, and treatment planning (Archer, 2013). Research has shown large effect sizes in the PAI's ability to detect malingering and over-reporting of psychopathology (Hawes & Boccaccini, 2009; Edens, Poythress & Watkins-Clay, 2007; Duncan & Ausborn, 2002). In regards to clinical diagnosis, the PAI has also been particularly useful in assessing for

negative affective disorders and an individual's proclivity towards substance abuse. Additionally, particular scales of the PAI, such as the Aggression (AGG) and Suicidal Ideation (SUI) scales, have been useful in predicting institutional adjustment for offenders (Walters, Duncan & Geyer, 2003). PAI scales, such as the Treatment Rejection (RXR) scale, have been found to be associated with social support. This scale has also positively predicted treatment non-compliance among sex offenders (Caperton, Edens & Johnson, 2004).

A widely used personality test, particularly for evaluating personality disorders, is the Millon Multiaxial Clinical Inventory (MCMI), which was the focus of the current study. The development, structure, and uses of the MCMI are further discussed in detail in the following section.

The Millon Clinical Multiaxial Inventory. The original Millon Clinical Multiaxial Inventory was developed from Theodore Millon's evolutionary theory of personality. Millon's theory sought to explain and operationalize the structure and styles of personality as it reflects biopsychosocial strivings (Grossman & Amendolace, 2017). Millon's theory describes personality structure as balanced, unbalanced, or conflicted. Millon considered the principles and processes of evolution as an universal phenomena that, however, could be expressed and be manifested in various forms. Millon soon came to assert that a mature clinical science of mental functioning would require the unification of the sciences rather than each field of science growing independently and autonomous of each other. Millon believed that the synergy of the sciences would embody the following: 1. Universal laws grounded in evolutionary theory found in nature; 2. Subject-oriented theories; 3. Classification of personality syndromes and psychopathology; 4.

Empirically-derived clinical assessment tools that are sensitive quantitatively to theory propositions and hypotheses to be evaluated (Millon, 1999).

As Millon's theory continued to evolve, he began identifying core motivating aims that give rise to unique personality strategies. Millon presented these unique personality strategies in three polarities: 1. Pleasure-Pain polarity; 2. Active-Passive Polarity; and 3. Self-Other polarity. The pleasure-pain polarity orients around whether individuals seek to increase their quality of life through the pleasure principle or seek to shy away from life-jeopardizing actions through the pain principle. The active-passive polarity represents the degree to which people put forth effort in altering their environment for it to become more suitable for themselves through the active orientation or accommodate to their environment through the passive orientation. Finally, the self-other polarity represents self-maximizing through the self orientation versus seeking kinship through the other orientation (Millon, 1999; Millon, 1990).

In light of the various dimensions identified in the personality structure, Millon developed combinations of the three polarities that were translated into 8 personality prototypes. The personality prototypes were to be conceptualized at a lower level than a clinical personality disorder. From the personality prototypes, Millon identified the corresponding DSM-III personality disorders that were to represent the personality prototype if the severity were to become clinically indicated (Choca, 1999). Table 1 presents a listing of Millon's progression from Personality Patterns to Personality Prototypes and corresponding DSM-III/IV diagnoses (American Psychiatric Association, 1980, 1994).

Table 1

Millon's Original 8 Personality Prototypes

Pattern	**Millon's Prototype**	**DSM-III/IV Diagnosis**
Passive Dependent	Submissive (Dependent)	Dependent Personality
Active Dependent	Gregarious (Histrionic)	Histrionic Personality
Passive-Independent	Narcissistic	Narcissistic Personality
Active Independent	Aggressive (Antisocial)	Antisocial Personality
Passive-Ambivalence	Conforming (Compulsive)	Compulsive
Active-Ambivalence	Negativistic (Passive-Aggressive)	Passive-Aggressive
Passive Detached	Antisocial (Schizoid)	Schizoid Personality
Active-Detached	Avoidant	Avoidant Personality

Source. Choca, J. P. (1999).

As the theory continued to develop throughout the MCMI revision, personality began to be viewed as a construct on a continuum ranging from adaptive to maladaptive. Likewise, the theory as reflected in the MCMI strived to illuminate the dimensions of personality rather than introducing hard "cut offs." Given this, each of Millon's identified personality prototypes have evolved to becoming clinically assessed in three ranges on a continuum: normal style, abnormal trait/type, and clinical disorder (Grossman & Amendolace, 2017; Millon, Davis & Millon, 1994).

MCMI. The purpose of the original Millon Clinical Multiaxial Inventory was to be an operational measure of a syndrome derived from a theory of personality and psychopathology (Millon, 1969, 1981, 1990). The MCMI included 175 True/False self-report items that had been arranged in 20 clinical scales that were designed to correspond

with the DSM-III clinical criteria. Schizoid (1), Avoidant (2), Dependent (3), Histrionic (4), Narcissistic (5), Antisocial (6), Compulsive (7), and Passive Aggressive (8) scales were intended to assess for basic maladaptive personality styles. Schizotypal (S), Borderline (C), and Paranoid (P) scales reflected personality disorders that involve greater pathology in their function. Anxiety (A), Somatoform (H), Hypomania (N), Dysthymia (D), Alcohol Abuse (B), and Drug Abuse (T) scales evaluated for clinical syndromes of moderate severity, while Thought Disorder (SS), Psychotic Depression (CC), and Delusional Disorder (PP) scales assessed for clinical syndromes of pronounced severity (Craig, 2013). The various scales were constructed to assist in distinguishing between enduring personality characteristics of patients as indicated on Axis II of the DSM-III from acute clinical disorders that are often displayed within the realm of Axis I within the DSM-III (Bassett & Beiser, 1991).

A unique feature of the MCMI is the use of base rate (BR) scores, as most personality inventories use a T-score system to determine scale score elevations and clinical cut off scores. However, on the MCMI, the base rates are translated from the obtained raw scores to represent a standard score that takes the frequency of occurrence of the disorder into account. The purpose of a standard score is to analyze the examinee's score relative to the normative group. Base rates are presented on a continuum to represent the degree of severity and pervasiveness of the personality construct being assessed. Moreover, base rates are utilized as an acknowledgement that an individual can range from normal functioning to having a clinical disorder with increasing maladaptive and inflexible functioning as one moves further along the continuum. A BR score of 60 on the MCMI corresponds with the median raw score. For the personality disorder scales,

a BR score of 75 is indicative of the *presence* of a trait, while a BR score of 85 indicates the *presence* of a clinical disorder. For Scales A through PP, a BR score of 75 signifies the *presence* of syndrome and a BR score of 85 suggests the *prominence* of a syndrome (Millon, 1981).

The clinical utility of MCMI scales in practice is to assist clinicians in differentiating persistent and pervasive features of patients' psychopathological functioning from those features that are transient in nature. The MCMI assessment tool was designed in a manner that would highlight longstanding characterological patterns and distinguish those patterns from distinctive clinical symptomatology that arises when the patient is in distress. Additionally, the MCMI was designed to be able to assess the severity of the characterological patterns in addition to the presence of those patterns. Likewise, clinical symptomatology is assessed through various scales, with the more severe clinical symptomatology involving a more psychotic nature. Given the nature of the test, the MCMI was primarily designed to be used in clinical settings as a diagnostic screener or clinical assessment rather than a general personality instrument used with the "normal" population. These clinical settings would often include mental hospitals, courts, college counseling, private practice, outpatient agencies, and community mental health centers (Millon, 1992).

Some identified strengths of the MCMI relative to other measures were as follows: it was a shortened inventory in comparison to other personality inventories, it has a theory based scale construction, and it contained weighted items to assess the degree of deviation from the mid-range composite raw score. The latter feature was notably helpful in detecting "faking good" and "faking bad" responders. However, some

identified critiques of the MCMI have centered on its problems regarding scale interpretations, as some argued that base rate cut scores should not be used as a psychometric tool (Meehl & Rosen, 1955). Rather, researchers have advocated for alternative base rate scores that vary based on locality to optimize diagnostic accuracy. Likewise, the overlap of items across MCMI scales did not allow for the scales to be evaluated on an individual basis, nor did it allow for the relationship among disorders to be measured (Widiger & Corbitt, 1993).

MCMI-II. The Millon Clinical Multiaxial Inventory - II (MCMI-II; Millon, 1987) contained 175 items organized in 22 personality disorder and clinical syndrome scales, primarily to be used in clinical settings with individuals requiring mental health services. The revision of the original MCMI was made in response to the anticipation of the DSM-III-R in 1987 (Millon, 1987). The updated MCMI included two new personality disorder scales (Self-Defeating and Sadistic). Additionally, 45 items were revised and/or replaced and modifier scales were introduced to accommodate for artificial score elevations caused by dysphoric mood, over-exaggeration tendencies, and other examinee factors. Additionally, this version of the MCMI included three validity scales: Disclosure, Desirability, and Debasement (Craig, 2013).

McCann (1989) published research establishing the convergent validity of the MCMI with the MMPI, the latter of which is the most widely used and researched assessment tool in clinical psychology. Specifically, McCann assessed the degree of convergence between their respective personality disorder scales using a clinical sample. McCann replicated his work using a similar clinical sample in 1991, correlating the MMPI and the MCMI-II. He found that the correlation between the two tests measuring

similar constructs increased for all scales in the MCMI-II in comparison to the original MCMI. The only exception had been for the narcissistic scale, for which correlation with the MMPI decreased from .78 for the MCMI to .65 for the MCMI-II (McCann 1989; McCann 1991). These findings provided evidence that the MCMI-II represented an improvement over the original MCMI in construct validity.

MCMI-III. Similar to the MCMI-II, the Millon Clinical Multiaxial Inventory-III (MCMI-III; Millon, Davis, & Millon, 1994) contained 175 self-report items, maintaining the original purpose of assessing personality, emotionality, and test-taking approach. The MCMI-III was comprised of a total 29 scales - 24 personality disorder and clinical syndrome scales and 5 test-taking approach scales. Since the MCMI-II, the new revision added two scales - Depressive (2b) and Post-traumatic Stress Disorder (R)- and renamed pre-existing scales that were present in the MCMI-II version. The MCMI-III also added two Random Response scales - V (Invalidity) and W (Inconsistency) to further assist in assessing examinees' test-taking approach and test validity. Table 3 presents a full listing of MCMI scales changes throughout the original, second, and third revision.

In addition to the changes in the MCMI scales shown in Table 2, Millon and Grossman introduced 42 Grossman facet scales to the MCMI-III to correspond with the 14 primary personality scales. The Grossman facet scales were developed to serve a similar purpose as the content scales found in other commonly used personality instruments such as the MMPI. However, these facet scales were developed to analyze the expression of personality as a trait. Specifically, the introduction of the MCMI-III Grossman facet scales have allowed for improved definition of the key components of an elevated personality scale score. This is particularly beneficial in enabling assessment and

treatment planning to target the differences in endorsed symptoms within the same primary personality scale (Grossman, 2008).

(continues)

Table 2

MCMI-I, MCMI-II, and MCMI-III Scale Designations

MCMI-I	MCMI-II	MCMI-III
Basic Personality Patterns	Clinical Personality Patterns	Clinical Personality Patterns
1. Schizoid (Antisocial)	1. Schizoid	1. Schizoid
2. Avoidant	2. Avoidant	2A. Avoidant
		2B. Depressive
3. Dependent (Submissive)	3. Dependent	3. Dependent
4. Histrionic (Gregarious)	4. Histrionic	4. Histrionic
5. Narcissistic	5. Narcissistic	5. Narcissistic
6. Antisocial (Aggressive)	6A. Antisocial	6A. Antisocial
	6B. **Aggressive**	6B. **Sadistic** (Aggressive)
7. Compulsive (Conforming)	7. Compulsive	7. Compulsive
8. Passive Aggressive (Negative)	8A. Passive Aggressive	8A. Negativistic (Passive Aggressive)
	8B. **Self-Defeating**	8B. Masochistic (Self-Defeating)
Pathological Personality Disorders	Severe Personality Pathology	Severe Personality Pathology
S Schizotypal	S Schizotypal	S Schizotypal
C Borderline (Cycloid)	C Borderline	C Borderline
P Paranoid	P Paranoid	P Paranoid
Clinical Syndromes	Clinical Syndromes	Clinical Syndromes
A Anxiety	A Anxiety	A Anxiety
H Somatoform	H Somatoform Disorder	H Somatoform Disorder
N Hypomania	N **Bipolar: Manic Disorder**	N Bipolar: Manic Disorder
D Dysthymia	D Dysthymic Disorder	D Dysthymic Disorder
B Alcohol Abuse	B Alcohol **Dependence**	B Alcohol Dependence
T Drug Abuse	T Drug **Dependence**	T Drug Dependence
		R Post-traumatic Stress Disorder
Severe Syndromes	Severe Syndromes	Severe Syndromes
SS Thought Disorder	SS Thought Disorder	SS Thought Disorder
CC Psychotic Depression	CC **Major** Depression	CC Major Depression
PP Delusional Disorder	PP Delusion Disorder	PP Delusion Disorder

(Table 2 continues)

Table 2 (cont.)

MCMI-I	MCMI-II	MCMI-III
	Modifier Indices	Modifier Indices
	X Disclosure	X Disclosure
	Y Desirability	Y Desirability
	Z Debasement	Z Debasement
		V (Invalidity), W (Inconsistency)

Note. From Krishnamurthy, R. (2017, Spring). Changes made across revisions of the MCMI are indicated in bolded letters.

Despite the improvements made between the MCMI-II and MCMI-III, the MCMI-III did not go without criticism. For instance, test reviewers have highlighted concerns relating to many test items loading onto multiple scales, which likely compromises statistical analyses derived on the MCMI-III (Hess, 1998).

MCMI-IV. The Millon Multiaxial Clinical Inventory-IV (MCMI-IV; Millon, Grossman & Millon, 2015) is a substantially revised version of the MCMI-III, comprised of 195 self-report items. One of the ways in which it has been altered is the addition of 20 new items. The focal purpose of the MCMI-IV is to identify personality patterns as it relates to clinical symptomatology, notable concerns, and test-taking approach to inform treatment implications. Additionally, this revision also included the following features: updated norms, new test items, renaming of the scales, and being designed to closely align with the updated DSM-5 (American Psychiatric Association, 2013) criteria. The new standardization sample for the MCMI-IV consisted of 1,547 adults from clinical settings within the age range of 18 to 85. The new normative sample was diverse in education attainment, geographical region, ethnicity, gender, and marital status. A

Turbulent scale was added with the new revision, which primarily assesses for persistent high-spirited behavior that is often erratic or reckless in nature. The MCMI-IV includes 5 validity scales, 15 personality scales, 45 facet scales, and 10 clinical syndrome scales. A full listing of the scale names and descriptions are located in Table 3. Finally, unlike other versions of the MCMI, the scoring system was updated with the MCMI-IV edition, which no longer allows for hand scoring. Test results may be obtained through mail-in answer sheets, online administration, or program scoring through Q Local (MCMI-IV; Millon, Grossman & Millon, 2015).

(continues)

Table 3

Description of MCMI-IV Scales and Subscales

Scales (Subscales)	**Measured Characteristics**
Clinical Personality Patterns	Clinical Scale Descriptions
1. Schizoid	Incapacity to experience deep pleasure or pain; indifference to social relationships; distant, listlessness, and asocial leanings; low affectionate needs.
(1.1) Interpersonally Unengaged	Interpersonally unengaged and unresponsive to the needs of others; lacks desire or enjoyment in close relationships.
(1.2) Meager Content	Lacks in internalized object representations; largely devoid of the various perceptions and memories of relationships.
(1.3) Temperamentally Apathetic	Emotionally unexcitable; possesses weak affectionate or erotic needs; rarely displays feelings of warmth.
2A. Avoidant	Frequently guarded and ready to distance self from life's painful or negatively reinforcing experiences; desire to engage with others but has the tendency to deny these feelings and to maintain interpersonal distance.
(2A.1) Interpersonally Aversive	Interpersonally aversive; frequently distances self from intimate personal relationships and reports history of social anxiety and distrust.
(2A.2) Alienated Self-Image	Alienated self-image; sees self as socially inept, inadequate, and inferior; personally feels unappealing and often underestimates own achievements.
(2A.3) Vexatious Content	Has limited avenues for experiencing or recalling gratification and few mechanisms to channel needs, resolve conflicts, or lessen external stressors.
2B. Melancholic	Experiences pain permanently with no experiences of pleasure; inclined towards pessimism and disheartened outlook on life or a sense of hopelessness.

(Table 3 continues)

Table 3 (cont.)

Scales (Subscales)	Measured Characteristics
Clinical Personality Patterns	Clinical Scale Descriptions
(2B.1) Cognitively Fatalistic	Has defeatist and fatalistic attitudes about most matters; views things in their bleakest form and invariably expect the worst; gloomy interpretations of current events and little hope for situations to improve.
(2B.2) Worthless Self-Image	Views self as valueless, insignificant, and inconsequential; believes one should be criticized and derogated, and should feel guilty for having no praiseworthy traits or achievements.
(2B.3) Temperamentally Woeful	Mournful, joyless, and morose emotional dispositions that are intensified by worrisome, pessimistic, and guilt-ridden tendencies.
3. Dependent	Lack of initiative or autonomy; often turns to others for nurturance and rarely takes on leadership roles; passive in interpersonal relationships; willingly submits to others in order to maintain their affection.
(3.1) Expressively Puerile	Withdrawn from adult responsibilities; displays few functional competencies and avoids self-assertion.
(3.2) Interpersonally Submissive	Interpersonally submissive to stronger, nurturing figures; needs frequent reassurance and advice.
4A. Histrionic	Tends to maximize the attention and favors from others through enterprising manipulation; appears outwardly confident but is internally insecure and frequently has a need for approval.
(4A.1) Expressively Dramatic	Over-reactive, volatile, provocative, and engaging; tends to be easily excited and has low tolerance for frustration, delay, and disappointment; highly emotionally theatrical responsiveness.
(4A.2) Interpersonally Attention-Seeking	Actively solicits praise and manipulates others to gain needed reassurance, attention, and approval.

(Table 3 continues)

Table 3 (cont.)

Scales (Subscales)	Measured Characteristics
Clinical Personality Patterns	Clinical Scale Descriptions
(4A.3) Temperamentally Fickle	Highly emotionally responsive; vacillates between positive and negative affect with unusual ease.
4B. Turbulent	Maintains persistent high-spirited behavior that may irritate others; often bored and lacks the consistency to complete goals and plans; Behavior can come across as erratic or reckless and can be followed by depressive exhaustion.
(4B.1) Expressively Impetuous	Forceful, driven, emotionally excitable, and zealous with a high degree of animation and restlessness.
(4B.2) Interpersonally High-Spirited	Attempts to engage with others with an infectious enthusiasm; may become overbearing, intrusive, and needlessly insistent.
(4B.3) Exalted Self-Image	Views self as ambitious, inspiring, and has illusions of invincibility.
5. Narcissistic	Experiences pleasure by focusing on self; demonstrates feelings of superiority or arrogant self-assurance; may exploit others; welcomes praise and encouragement from others, although their feelings of superiority are not dependent on it.
(5.1) Interpersonally Exploitative	Feels entitled, lacks empathy, and expects special favors without assuming reciprocal responsibilities.
(5.2) Cognitively Expansive	Undisciplined imagination and preoccupation with immature and self-glorifying fantasies of success, beauty, and love.
(5.3) Admirable Self-Image	Believes self to be special, unique, and deserving of great admiration; grandiose and self-assured without paralleled achievements.

(Table 3 continues)

Table 3 (cont.)

Scales (Subscales)	Measured Characteristics
Clinical Personality Patterns	Clinical Scale Descriptions
6A. Antisocial	Desires autonomy; wishes for revenge and recompense for perceived past injustices; engages in duplicitous or illegal behavior designed for self-gain; often characterized as disloyal, impulsive, unsensitive, and ruthless.
(6A.1) Interpersonally Irresponsible	Interpersonally irresponsible; often untrustworthy and unreliable; negates personal obligations.
(6A.2) Autonomous Self-Image	Unreliable, untrustworthy, and dishonest tendencies; often violates the rights of others; transgresses against established social codes.
(6A.3) Acting-Out Dynamics	Unconstrained expression of offensive thoughts and malevolent actions; views self as the victim and does not feel the need to rationalize one's outbursts.
6B. Sadistic	Seeks personal pleasure and satisfaction through ways of humiliating others; generally hostile and pervasively combative; presents as dominating, antagonistic, and frequently persecutory.
(6B.1) Expressively Precipitate	Insensitive to others and prone to argumentativeness and contentiousness; tendency to have unwarranted outbursts and become easily provoked.
(6B.2) Interpersonally Abrasive	Finds pleasure and satisfaction in intimidating, coercing, humiliating, or degrading others.
(6B.3) Eruptive Architecture	Surging inner energies of an aggressive or sexual nature; in a constant state of dread at the thought of being vulnerable, deceived, and humiliated.
7. Compulsive	Often intimidated and coerced into accepting demands and judgments from others; demonstrates disciplined self-restraint to control intense, though hidden, oppositional feelings.

(Table 3 continues)

(Table 3 cont.)

Scales (Subscales)	Measured Characteristics
Clinical Personality Patterns	Clinical Scale Descriptions
(7.1) Expressively Disciplined	Highly structured and strictly organized life; efforts toward perfectionism may limit alternatives and make ordinary tasks difficult to complete.
(7.2) Cognitively Constricted	Constructs the world in terms of rules, regulations, time schedules, and social hierarchies; tends to be rigid and stubborn.
(7.3) Reliable Self-Image	Views self as efficient, disciplined, meticulous, and industrious; minimizes the importance of recreational and leisure activities.
8B. Masochistic	Relating to others in a self-sacrificing manner; often focuses on their worst features and assert that they deserve to be shamed and humbled; actively and repetitively recall their past misfortunes and expect problematic outcomes from otherwise fortunate events.
(8B.1) Underserving Self-Image	Self-abasing and views self as worthy of shame; often amplify their worst features and believes they deserve to suffer painful consequences when expectations of others are not met.
(8B.2) Inverted Architecture	Experiences pleasure when pain is the more appropriate reaction, and pain when pleasure is more fitting.
(8B.3) Temperamentally Dysphoric	Anxious and apprehensive at times while forlorn and mournful at others; induces guilt and discomfort in others.

(Table 3 continues)

(Table 3 cont.)

Scales (Subscales)	Measured Characteristics
Severe Personality Pathology Scales	Severe Personality Pathology Descriptions
S. Schizotypal	Socially isolative with minimal personal attachments and obligations; often viewed as strange or different; inclined towards cognitive disorganization.
(S.1) Cognitive Circumstantial	Mixes social communication with personal irrelevancies; appears self-absorbed and lost in daydreams with occasional magical thinking.
(S.2) Estranged Self-Image	Experiences repetitive personal confusion and social perplexities; has deficient cognitions and a disharmonious affect.
(S.3) Chaotic Content	Ineffective and uncoordinated framework for regulating tension, needs, and goals.
C. Borderline	Presents with unstable and labile affect; displays cognitive affective ambivalence evident in conflicting feelings of rage, love, and guilt toward others.
(C.1) Uncertain Self-Image	Immature and wavering sense of identity; underlying feelings of emptiness.
(C.2) Split Architecture	Inconsistent and incongruent psychic structure resulting in contrasting perceptions, memories, and affect.
(C.3) Temperamentally Labile	Emotionally unstable with mood levels that are rarely in accordance with external reality.
P. Paranoid	Displays vigilant mistrust of others and defensiveness against anticipated criticism; has immutable feelings and inflexible thoughts; fears losing independence, leading to vigorously resisting external influence and control.
(P.1) Expressively Defensive	Guarded and maintains a hypersensitive wariness in order to ward off anticipated deception and malice from others.

(Table 3 continues)

(Table 3 cont.)

Scales (Subscales)	Measured Characteristics
Severe Personality Pathology Scales	Severe Personality Pathology Descriptions
(P.2) Cognitively Mistrustful	Suspicious about the motives of others and tends to misconstrue innocuous events as signifying proof of duplicity or conspiratorial intent.
(P.3) Projection Dynamics	Actively disowns undesirable personal traits and motives, and attributes them to others.
Clinical Syndrome Scales Descriptions	Clinical Syndrome Scale
A. Generalized Anxiety	Demonstrates a generalized state of tension manifested in inability to relax; complains of physical discomfort; often has an excessive alertness to their environment.
H. Somatic Symptom	Often preoccupied with ill health; experiences persistent periods of fatigue and physical discomforts; has the tendency to over-interpret real medical diagnoses.
N. Bipolar Spectrum	Experiences periods of elations, inflated self-esteem, restless overactivity and distractibility, pressured speech, impulsiveness and irritability; demonstrates flight of ideas and rapid and labile mood.
D. Persistent Depression	Preoccupied with feelings of discouragement or guilt, lack of initiative, behavioral apathy, and low self-esteem; has a pessimistic outlook on the future, social withdrawal, possible chronic fatigue, and weight and appetite variability.
B. Alcohol Use	Increased likelihood of recurrent or recent history of alcoholism; has had little success overcoming alcoholism.
T. Drug Use	Increased likelihood for recurrent or recent history of drug abuse and is likely unable to manage the personal consequences of their behavior.
R. Post-Traumatic Stress	Experienced or witnessed an event involving actual or threatened death or serious injury causing a response of fear, feelings of helplessness, or horror; events are often re-experienced through nightmares and flashbacks, resulting in severe distress.

(Table 3 continues)

(Table 3 cont.)

Scales (Subscales)	Measured Characteristics
Severe Clinical Syndromes Scales	Severe Clinical Syndrome Scale Descriptions
SS. Schizophrenic Spectrum	Periodically exhibits incongruous, disorganized, or regressive behavior; appears disorganized or confused and may display inappropriate affect, hallucinations, and unsystematic delusions.
CC. Major Depression	Incapable of functioning in a normal environment; has a pessimistic outlook on future, a pervasive sense of hopelessness, and possible suicidal ideation.
PP. Delusional	Acute paranoia and may become periodically belligerent, voicing irrational but interconnected delusions of a jealous, persecutory, or grandiose nature; may exhibit signs of disturbed thinking and suspiciousness and vigilance to possible betrayal.

Adapted from Millon, T., Grossman, S., Millon, C. (2015).

Estimates of internal consistency were provided for the 15 personality scales, 45 facet scales, and 10 clinical scales. The 15 personality scales exhibited a strong range of internal consistency, yielding alpha coefficients ranging from .67 to .92. Compulsive (.67), Narcissistic (.75), and Antisocial (.78) scales were the only personality scales with internal consistency coefficients lower than .80. The 45 facet scales yielded reasonably strong internal consistency alpha coefficients, ranging from .63 to .88. Finally, the internal consistency for the 10 clinical scales also demonstrated relatively strong internal consistency coefficients ranging from .65 to .93. The lowest estimates of internal consistency were for the Alcohol Use (.65) and the Bipolar Spectrum (.71) scales. The strength of the test-retest coefficients, however, varied across the groupings of scales. Notably, the facet scales test-retest coefficients ranged greatly from .56 to .94, while the

personality scales yielded higher correlation coefficients of .81 to .93 and the clinical scales yielded a range from .73 to .89 (Rouse, 2017; Millon et al., 2015).

Empirical Findings on MCMI Use with Inmates

Various types of research have been conducted utilizing the MCMI with offender samples. The primary bases for the MCMI research have been exploratory, such as to analyze the factorial structure of the MCMI to identify clustering of scales relevant to the specific inmate population and to assess for psychological impacts of specific housing areas within the correctional setting. Research regarding the MCMI has also been used to evaluate similarities in scale score elevations of inmates with similar criminal charges, to discriminate scale scores identified in inmates with different types of charges, and to make predictions regarding inmates' institutional adjustment and misconduct.

Dozois and Kelln (1999) examined the utility and factor structure of the MCMI-III in an offender population. Participants of the study included 159 adult male inmates housed at a federal medium security facility, who had been incarcerated for crimes against property (42%), drug and alcohol- related offenses (20%), sexual offenses (16%), assaults (13%), and homicide (9%). The researchers obtained the inmates' MCMI-III testing data that was routinely administered at the time of admission to the facility as well as their demographic information. A factor analysis of the 10 clinical scales revealed that variances in participants' responses were best accounted for by two factors – a Psychiatric Disturbance factor and a Substance Dependence factor. The Psychiatric Disturbance factor included the following clinical scales on the MCMI-III: Anxiety, Somatoform, Manic, Dysthymic, Post-traumatic Stress Disorder, Thought Disorder,

Major Depression, and the Delusional scale. The Substance Dependence factor was comprised of the Alcohol and Drug Dependence scales. The Substance Dependence factor has been important in identifying clinically-relevant behavioral manifestations whereas the Psychiatric Disturbance factor is indicative of psychological functioning. Notably, the Bipolar/Mania scale was the only scale to load onto both factors. In analyzing the personality pattern scales of the MCMI-III, three factors emerged - Internalizing (Factor 1), Acting Out (Factor 2), and Self-Absorption (Factor 3). The Internalizing factor included positive loadings of the Schizoid, Avoidant, Depressive, Dependent, Passive-Aggressive, Self-defeating, Schizotypal, Borderline, and Paranoid scales, with a negative loading of the Histrionic scale likely due to the extraverted nature of the personality disorder. The Acting Out factor included positive loadings of the Antisocial, Aggressive, Passive-Aggressive, and Borderline scales and a negative loading of the Compulsive scale. Finally, the Self-absorption scale included a positive loading of the Narcissistic and Histrionic scales with a negative loading of the Dependent scale for the offender sample (Dozois and Kelln, 1999).

Versions of the MCMI have also been used to investigate inmate institutional adjustment due to housing environment. Many inmates are prone to have poor correctional institution adjustment through maladaptive behaviors, which may include suicide, rebellion, self-mutilation, incident reports, and resistance (Matthews, 2016). Research has historically taken special interest in inmate adjustment based on type of inmate housing within the confined setting. Specifically, research focused on solitary confinement has emphasized the negative social and psychological impact due to the reduction in meaningful contact and sensory stimuli (Smith, 2006). Chadick, Batastini,

Levulis, and Morgan (2018) examined the psychological impact of inmates being housed in administrative segregation. The researchers included a sample of 48 adult male inmates housed in the Kansas Department of Corrections. Twenty-four inmates included in the sample were being housed in the general population area and the remaining 24 inmates were being housed in administrative segregation. The practice of administrative segregation has been primarily used to separate disruptive inmates from the general population with the hopes of maintaining order. Inmates housed in administrative segregation are allowed to access art supplies, legal and other reading materials, and one hour of exercise per day for a least five days a week. The researchers gathered the participants' MCMI-III profiles that had been routinely administered during the initial intake process. The MCMI-III was re-administered to the 48 participants at the time of data collection. Results indicated that there were no detectable differences in psychological functioning between the two assessments for segregated inmates despite their length of time spent in segregation. On the other hand, inmates housed in the general population demonstrated some improvements in psychological functioning, likely attributed to accessible treatment options and programs.

Studies have also focused on examining the MCMI and its utility in predicting institutional adjustment and conduct of inmates. Kelln, Dozois and McKenzie (1998) examined MCMI-III scores of 128 male medium security prison inmates who had been housed for a minimum of 3 months. Thirty seven percent of the participants had been convicted of crimes against persons, whereas 63% of the participants had been convicted of "other" crimes that included property, drug, and alcohol- related offenses. Each inmate's demographic information and institutional records of behavior were obtained as

well as the MCMI-III data from testing done upon admission to the facility. Institutional misconduct was classified by the presence of official reprimands, days spent in segregated housing, early lockups, monetary penalties, and suspensions from facility programs. Kelln et al.'s (1998) results indicated inmates who had received behavioral reprimands were more likely to be of a younger demographic and have committed a crime against persons. Additionally, inmates in this grouping had also obtained higher scores on the following MCMI-III scales in comparison to their counterparts: Schizoid, Narcissistic, Antisocial, Aggressive, Passive-Aggressive, and Borderline. Likewise, inmates receiving behavioral consequences were likely to score lower on the Compulsive personality scale compared to inmates who were not receiving behavioral consequences. Inmates with misconduct reports also scored higher on the Alcohol Dependence and Thought Disorder scales than those without misconduct reports. Finally, the inclusion of MCMI test data in conjunction with inmate demographics increased the predictive accuracy of institutional misconduct by 33% compared to predictions made solely on inmate demographics alone (Kelln et al., 1998).

Unpublished dissertation research by Falotico (2003) assessed 84 inmates housed in the Dixon Special Treatment Center (STC) medium-security inpatient facility and the Dixon Psychiatric Unit (DPU) maximum-security inpatient psychiatric facility located in Dixon, Illinois for the purposes of evaluating the utility of the MCMI-III computerized report (MCMI-III; Millon, Davis, & Millon, 1998) in assessing and classifying inmates. Each participant was given the MCMI-III to complete, and a complete file review was conducted to obtain participants' disciplinary records for violence committed while incarcerated and the number of occasions each inmate had been placed on a crisis watch

status within six months prior to being tested. Falotico (2003) found an obtained base rate score of 75 or higher on the Post-Traumatic Stress Disorder (PTSD) scale was associated with fewer occasions of the inmate having been placed on a crisis watch status. However, a base rate of 75 or higher on the PTSD and Major Depression scales was associated with a higher number of disciplinary reports for violent offenses. A higher number of disciplinary reports given for non-violent offenses were also found to be related to a base rate score of 75 or higher for the following scales: Debasement, Depressive, Borderline, Somatoform Disorder, PTSD, Major Depression and Delusional Disorder (Falotico, 2003).

The MCMI has also been used as a psychological screener for specific offense inmates. For instance, the MCMI has been commonly used to examine personality traits and psychological functioning of sex offenders. Chantry and Craig (1994) administered the original MCMI to 603 convicted adult male violent offenders, whom had been grouped by the nature of their offense: child molesters (n = 202), rapists (n = 195), and non-sexually violent offenders (n = 206). Non-sexually violent offenses included first- and second- murder, voluntary and involuntary manslaughter, robbery, battery, assault, and non-sexual abuse of a child. The MCMI was given to each inmate as a part of routine screening procedures upon entrance to the reception and diagnostic center. Chantry and Craig (1994) found child molesters were more likely to have elevated scores on Passive-Aggressive, Anxiety, and Dysthymia scales in comparison to rapists and non-sexually aggressive inmates. Likewise, child molesters were also more likely to yield elevated scores on Schizoid, Dependent, Borderline, Psychotic Thinking, and Psychotic Depression scales in comparison non-sexually aggressive inmates. Child molesters and

rapists were more likely to elevate the Avoidant scale in comparison to non-sexually violent felons, and rapists had higher scores on the Passive-Aggressive scale in relation to non-sexually violent inmates. Non-sexually violent inmates and rapists both elevated the Narcissistic, Compulsive, and Paranoid scales with higher scores than child molesters.

In a sample of 7,921 adult male offenders admitted to the Colorado Department of Corrections (CDOC), Ahlmeyer, Kleinsasser, Stoner, and Retzlaff (2003) sought to examine the presence of personality disorders using the MCMII-III in sex offenders in comparison to general offenders. In this sample, 7,226 inmates included in the study were incarcerated for nonsexual offenses, which included offenses of robbery, fraud, drug offenses, and murder. The remaining 695 inmates of the sample were convicted of sexual offenses - specifically, 223 inmates were classified as rapists and 472 of the sample committed crimes against children and were classified as child molesters. The MCMI-III was administered to each inmate upon admission to the CDOC. Due to concerns of test score validity, approximately 10% of the MCMI-III profiles from the original sample were excluded from data analysis. Results from the final sample indicated inmates in the nonsexual offense sample had higher elevations on the Histrionic, Narcissistic, and Antisocial scales. Likewise, when examining the prevalence of personality disorders, the general offender sample had at least 20% of the sample yielding elevations over a base rate score of 74 on the following scales: Avoidant, Narcissistic, Antisocial, Negativistic, Anxiety, and Alcohol Abuse. The two sexual offense groups, collectively, demonstrates similar elevations on most scales excluding the Narcissistic scale. Additionally, the sex offender group also had 20% or more of their sample yield elevated scores on Depressive, Dependent, and Dysthymia scales. According to the Odds Ratio analysis, the

Schizoid, Depressive, Dependent, Avoidant, Self-defeating, and Schizotypal scales were likely to predict sex offender group membership. Furthermore, personality pattern scales, including Anxiety, Dysthymia, Somatoform, PTSD, Thought Disorder, Delusional Disorder, and Major Depression were also likely to predict sex offender group membership. Conversely, personality disorder scales, such as Narcissistic, Antisocial, Sadistic, and Drug Dependence were likely to predict membership in the nonsexual offense group. Finally, when comparing the two sex offender groups, rapists demonstrated a prevalence rate of 20% or more on the following scales: Avoidant, Antisocial, Negativistic, Anxiety, Depressive, and Alcohol Abuse. Alcohol Dependence scale was the only scale to predict rapist group membership. However, child molesters had a prevalence rate of 20% or more on Dependent, Dysthymia, and all other scales similar the rapist offender group. Predictors of child molesters included elevations on the following scales: Schizoid, Avoidant, Depressive, Dependent, Dysthymia, Major Depression, and Self-defeating. (Ahlmeyer et al., 2003).

The MCMI has also been heavily researched with behavior related to substance abuse among inmates. In a sample of 210 offenders, Garbarek, Bourke, and Van Hasselt (2002) studied female inmates who were being housed in a correctional institution located in South Florida and had identified problems related to substance abuse. Each participant completed the MCMI-III prior to participating in group therapy focused on problem-solving skills. The application of test score validity criteria eliminated 37 of the obtained MCMI-III profiles. Of the remaining 179 MCMI-III profiles, three personality groups were identified: normal, narcissistic, and antisocial. Forty eight percent of the participants fell within the antisocial cluster and 26% of the participants fell into the

narcissistic cluster (Garbarek et al., 2002). Notably, the prevalence rate of antisocial personality disorder appears to be consistent with other research results (e.g., Salekin, Randall, Rogers, & Sewell, 1997; 56% prevalence for antisocial personality disorders); however, the results in Garbarek et al.'s study appear to have a higher prevalence rate for narcissistic personality disorder in the sample compared to previous research (e.g. Strick, 1989; 2% prevalence rate for narcissistic personality disorder). Nonetheless, previous studies related to female alcohol dependent participants have consistently found elevations on the antisocial (McMahon & Tyson, 1990) and narcissistic (Matano, 1994) scales. Similarly, previous studies that have included male drug-dependent patients and male offenders have found similar clusters of narcissistic and antisocial personality features (Craig, 1997; Chantry & Craig, 1994). Millon (1987) also identified antisocial personality disorder as a common elevation among male alcohol dependent participants. However, personality features, such as borderline, histrionic, passive-aggressive, and dependent, found in previous research of adult male inmate samples and male substance users (Kelln et al., 1998; Matano et al., 1994) were not obtained in the results of Garbarek et al.'s study.

There have also been instances where the MCMI has been studied in conjunction with other assessment measures, particularly psychopathy measures, in the realm of forensic and correctional psychology. Hart, Forth, and Hare (1991) sought to examine the concurrent validity of the MCMI-II with the antisocial personality disorder (APD) criteria outlined in the DSM-III-R and the Psychopathy Checklist-Revised (PCL-R; Hare; 1980), a widely used 22-item assessment tool intended to assess the presence of psychopathic traits. The sample included 119 male offenders who were predominantly convicted of

violent offenses, were being housed in a medium security correctional facility, and were serving a sentence of at least two years. Each inmate underwent an assessment battery including the administration of the MCMI-II, a clinical interview, and a file review for the purpose of obtaining a psychopathy rating score on the PCL-R and/or to be diagnosed with Antisocial Personality Disorder (APD). An initial diagnosis was given from the PCL-R rater and the other diagnosis was offered from a rater blind to the inmates' PCL-R scores. The interrater agreement for the inmates' diagnoses was moderate ($k = .61$). Results indicated 79.2% of those who met criteria for psychopathy on the PCL-R were diagnosed with APD, and 30.2% of those diagnosed with APD met criteria for psychopathy on the PCL-R. In regards to the MCMI-II, the Antisocial scale was most correlated with PCL-R scores. Other significant MCMI-II scale correlations to PCL-R total scores included: Narcissistic, Aggressive/ Sadistic, Passive-Aggressive, Borderline, Paranoid, Drug Dependence, Thought Disorder, and Delusional Disorder. However, consistent with general criticisms of the MCMI, the MCMI-II appeared to be biased in measuring psychopathy and had low predictive ability for clinical diagnoses of psychopathy and APD given the high base rate sample (Hart et al., 1991).

Rationale and Hypotheses

Psychological research and census data have shown mental health difficulties to be a relevant concern for the inmate population. Psychological research relevant to the inmate population has often included the use of personality assessments to improve the understanding of personality structure and psychological difficulty of this population. Specifically, personality assessment has been used and researched to examine institutional adjustment, to identify the psychological characteristics of offenders with prior violence and substance involvement, and to determine subtypes of the types of offenders admitted in a local jail or prison environment. The MCMI is a widely used personality assessment measure in clinical and forensic populations. Nonetheless, the research literature regarding any version of the MCMI relevant to the inmate population is relatively limited. Additionally, the MCMI-IV has been recently released, and there is no current published research using this particular assessment tool. For any newly developed or revised test, a new body of research is needed to evaluate its effectiveness and use with different populations. The current study intended to address this goal.

The purpose of the current research was to establish correlates of the MCMI-IV scales in order to expand upon the current descriptions of the scales for jail inmates. This was achieved by utilizing a mental health checklist administered to inmates in a local jail setting in central Florida. Given the recency of the MCMI-IV publication in 2015, there is no published research to date on its use with jail or prison inmates. Specifically, there are no prior correlate studies with the MCMI-IV with inmates to guide the current research. The study, therefore, largely followed an exploratory approach in the establishment of

correlates. However, some expectations were proposed, guided by research findings from earlier versions of the MCMI and from the descriptions of the MCMI-IV scales.

Hypothesis 1. Substance abuse related variables of the mental health screener would be correlated with MCMI-IV scores for Antisocial, Borderline, Histrionic, Sadistic, and Dependent disorder scales (Craig, 1997; Chantry & Craig, 1994; Kelln et al., 1998; Matano et al., 1994).

Hypothesis 2. Suicide-related risk factors and inpatient treatment would be correlated with scores on the following clinical personality MCMI-IV scales, given the nature of the scale descriptions: Dependent, Melancholic, Schizoid, Compulsive, and Negativistic scales, based on research using the MCMI-III and PAI (Falotico, 2003; Walters, Duncan & Geyer, 2003).

Hypothesis 3. Adult male offenders with violent histories would likely to produce higher means scores on the following MCMI-IV scales in comparison to their non-violent offending peers: Antisocial, Sadistic, and Borderline scales (Dozois and Kelln, 1999).

Methods

Participants

Participants of this study consisted of 97 male adult inmates housed at a local county jail complex located in central Florida who had been referred to the jail's mental health services. They were derived from general population (49.5%), acute mental health (41.%), and detox (9.5%) housing areas of the jail. Inclusion criteria for the participants in this study included: (a) male inmates age 18 or older who have at least a fifth-grade reading level ability, determined by successful completion of at least the fifth grade. (b) being referred to the mental health housing area for further mental health evaluation and monitoring at the time of their participation in this study; and (c) generating a valid MCMI-IV profile. A mental health housing referral may be initiated for the following reasons: a long-standing mental health history, acute/crisis mental health presentation at the time of booking (e.g. actively experiencing psychotic symptoms, suicidal, homicidal, or an inmate admitted on an active Baker Act), or placement of the inmate on an active substance detox protocol. For the participants' MCMI-IV scores to be considered valid in this present study, each test profile needed to have a Validity (V) raw score < 2, Inconsistency (W) raw score < 2, Disclosure (X) scale score of > 7 or < 114. Of the 97 participants, two were excluded from this study due to high Validity raw scores. The remaining 95 participants' scores were used in the data analyses for this study.

Table 4 provides details of the research sample including demographics, diagnoses given prior to admissions, substance use, charges, and prior incarceration.

Table 4

Descriptive Statistics for the Total Sample (n=95)

Demographics	n	%
Age		
18-25	26	27.4%
26-50	61	64.2%
50-65	8	8.4%
65 and up	0	0%
Education		
0-12 years of school	24	25.3%
High school diploma or equivalent	47	49.5%
Some college or technical training	18	18.9%
Bachelor's degree or more	6	6.3%
Race/Ethnicity		
White	48	50.5%
African American	40	42.1%
Other	6	6.3%
Hispanic	1	1.1%
Asian	0	0%
Marital Status		
Never Married	60	63.2%
Divorced	19	20.0%
Remarried	5	5.3%
Widowed	5	5.3%
First Marriage	3	3.2%
Separated	2	2.1%
Other	1	1.1%
Cohabiting	0	0%
Self-reported Diagnosis by History		
None	42	44.2%
Multiple Diagnoses	26	27.4%
Unknown	6	6.3%
Neurodevelopmental Disorder	5	5.3%
Anxiety Disorder	4	4.2%
Schizophrenia Spectrum and Other Psychotic Disorders	3	3.2%
Depressive Disorder	3	3.2%
Trauma- and Stressor-Related Disorders	3	3.2%
Bipolar and Related Disorders	2	2.1%
Somatic Symptoms and Related Disorder	1	1.1%

(Table 4 continues)

(Table 4 cont.)

Demographics	n	%
Substance Use		
Alcohol	52	54.7%
Marijuana	28	29.5%
Opiates	4	4.2%
Ecstasy	3	3.2%
Cocaine	2	2.1%
Heroin	1	1.1%
Benzodiazepines	2	2.1%
Methamphetamines	2	2.1%
Other	1	1.1%
Multiple Substance Categories	24	25.3%
None	28	29.5%
Housing Location		
General population	47	49.5%
Acute/Mental Health	39	41.1%
Detox	9	9.5%
Current Charges		
Offense resulting in bodily harm, not death	33	34.7%
Possession of illegal substances and drug paraphernalia	20	21.1%
Offense resulting in death	15	15.8%
Violation of Property	12	12.6%
Other	11	11.6%
DUI or other drug-related offense	4	4.2%
Violent v. Non-violent Offenders		
Violent	53	54.7%
Non-violent	42	45.3%
Prior Incarceration		
Yes	77	81.1%
No	18	18.9%

The age range of the sample extended from 18 years to 63 years with a mean age of 35.9 (SD = 11.2). As seen in Table 4, participants were predominately White or African American, together constituting approximately 93% of the sample. They were

mostly never married individuals who received a high school diploma or an equivalent level of education.

Slightly more than 40% of the sample reported having no prior psychiatric diagnoses. However, when diagnostic information was provided, it typically consisted of multiple diagnoses. In regards to participants' prior substance use, alcohol and marijuana were reported as the most frequently used substances prior to incarceration.

Among the various charges levied against participants as shown in Table 4, the largest percentage (35%) of participants included had been charged with an offense resulting in bodily harm but not death. These offenses included, but were not limited to, attempted murder, aggravated robbery, aggravated assault, battery, child abuse, and domestic violence. The sample was fairly evenly distributed between violent and non-violent offenders. The vast majority of participants had also been previously incarcerated.

Instruments

This study utilized the Millon Clinical Multiaxial Inventory-Fourth Edition and a combined initial assessment and risk assessment form completed by mental health staff.

MCMI-IV (Millon, Grossman & Millon, 2015)

The MCMI-IV was the focal instrument utilized in this study. As previously discussed, the MCMI has been utilized and researched in forensic and correctional settings involving inmate samples. The MCMI-IV has been shown to demonstrate overall strong psychometric properties. The internal consistency for the MCMI-IV scales, as reported in the MCMI-IV test manual, indicated reasonably strong alpha coefficients ranging from .67 to .92 across its scales and subscales, with most scales reaching above .80. Test-retest reliability coefficients ranged from .56 to .94 for a sample of 129

examinees retested within a five-to-fourteen-day interval, with higher coefficients for the scales in comparison to subscales (Rouse, 2017; Millon et al., 2015).

The validity of the MCMI-IV was examined for the scales and subscale scores with evidence of convergent and discriminant patterns. Additional test score validity evidence came from correlations with other measures including the Brief Symptom Inventory (BSI), MMPI-2-RF, and the MCMI-III, once again demonstrating appropriate convergent validity. For example, MCMI-IV Avoidant, Melancholic, and Masochistic personality pattern scales had strong correlations with the BSI's Interpersonal Sensitivity scale, consistent with theoretical expectations. Similarly, the MCMI-IV General Anxiety and Somatic Symptom scales had moderate to strong correlations with the MMPI-2-RF's Emotional/Internalizing Dysfunction, Somatic Complaints, head complaints, and anxiety scales (Millon et al., 2015). Furthermore, there were indications of consistency between scores of the MCMI-IV scales and their MCMI-III counterparts (Rouse, 2017). Overall, the psychometric properties of the MCMI-IV have been judged to be favorable (Rouse, 2017).

Combined Initial Assessment and Suicide Risk Assessment Form

The combined initial assessment and suicide risk assessment form is a tool completed and utilized by the mental health staff at the local county jail for each inmate referred to the mental health unit. The intended purpose of this form is to assist the mental health staff in determining the level of risk of each mental health referral through an individual semi-structured interview. The form includes the following information: basic demographic data; current charges and previous incarceration experience; social history and family history; psychiatric and medical history; alcohol and drug dependence

involvement; violence history and risk; suicidal ideation and history; and a mini-mental status summary.

The social history and family history section of the assessment form contains information such as educational background, family mental health history, and marital status prior to incarceration. The psychiatric and medical history provides information on previous mental health diagnoses given by a provider, history of psychiatric inpatient hospitalizations, current psychotropic prescription medications, medical complaints, and abuse history. The alcohol and drug dependence involvement section includes information regarding previous and current substance use, prior substance abuse treatment received, previous withdrawal experiences, and family history of substance abuse. Violence history and risk includes information on previous violent arrests such as assault/battery and domestic violence, the presence of homicidal ideation, and potential unusual risk for victimization (e.g. lower intellectual functioning). The suicidal ideation and history section focuses on the inmate's current and previous experiences of suicidal ideation, plan, and intent. Protective and risk factors are also assessed at this point of the semi-structured interview. Protective factors include the presence of coping strategies, stated reasons for living, hope factors, and an identified plan to address future suicidal ideation if the occasion were to arise. Some risk factors are depressed mood, recent critical life changes prior to incarceration, and potential problems related to incarceration that surpass what is to be expected within the given population.

Appendix B presents the Combined Initial Assessment and Suicide Risk Assessment form.

Procedure

This study was initiated after receiving the approval of the Institutional Review Board at Florida Institute of Technology and the Doctoral Research Project committee. Pre-authorization to conduct this study was obtained by the Director of Mental Health Services at the local county jail. Adult male inmates who had been referred for mental health services were recruited from the local county jail. The Director of the Mental Health Services provided the researcher with a listing of eligible participants according to the inclusion criteria previously outlined. The researcher briefed each eligible participant individually on the details of the study, and a verbal agreement was obtained prior to relocating the inmate from his cellblock to the room designated for testing. Upon entry into the testing room, the researcher reviewed the informed consent with each participant. Following the review of the informed consent form, procedures to ensure confidentiality was explained to each participant, including the removal of all identifying information (e.g. names) on all documents exported and used for data analysis purposes. Additionally, participants of this study were advised that their participation was voluntary and there would not be any adverse consequences for non-participation. Participants were assigned a numerical identifier in place of their identifying information for the purposes of data collection to further ensure privacy. After the inmates agreed to participate by providing a signature on the informed consent and had been briefed on confidentiality standards, they completed the MCMI-IV individually or in a small-group format, under the supervision of the researcher of this study and a security staff officer at the Brevard County Jail. Participants in the maximum security housing area were administered the MCMI-IV in a group format, given the increased space within the cellblock. There were approximately

five to six inmates per group testing. All other participants housed in other areas of the jail were tested on an individual basis due to room constraints.

The obtained MCMI-IV responses and scores, and relevant information obtained on the Combined Initial Assessment and Suicide Risk Assessment form, were transferred to the Statistical Package for the Social Sciences (SPSS) database for analysis. After data collection was completed, the sample was subdivided into violent (n=53) and non-violent (n=42) groups to address hypothesis 3. Participants charged with offenses against another person resulting in death or injury were included in the violent sample. All other participants were placed in the non-violent sample.

Data Analyses

Preliminary analysis consisted of computing descriptive statistics that described the characteristics of the sample. The analysis included obtaining means, standard deviations, and percentage data. Means and standard deviations of MCMI-IV scores were also generated. The central analysis consisted of biserial correlations to examine the relationships between MCMI-IV scores and variables from the mental health screener (i.e., social and family history, psychiatric and medical history, alcohol and drug involvement, violence history and risk, and suicidal ideations and history). Significant correlations with effect sizes of .30 or higher were used to establish correlates of MCMI-IV scale scores. Additionally, a multivariate analysis of variance (MANOVA), followed by univariate analyses, was conducted to examine the differences in MCMI-IV personality characteristics between violent and non-violent offenders.

Results

Preliminary analyses consisted of computing the means (M) and standard deviations (SD) of the MCMI-IV score means for the total sample (N = 95) of inmate participants. Results are shown in Table 5.

Table 5

MCMI-IV Score Means and Standard Deviations for the Total Sample (N=95)

MCMI-IV Scale and Subscales	M	SD
Response Style		
Disclosure	*72.7*	15.2
Desirability	60.6	19.2
Debasement	59.9	21.7
Clinical Personality Patterns		
1. Schizoid	*65.9*	21.5
1.1 Interpersonally Unengaged	*68.6*	15.9
1.2 Meager Content	52.1	26.7
1.3 Temperamentally Apathetic	62.3	24.7
2A. Avoidant	60.3	25.7
2A.1 Interpersonally Aversive	62.7	21.0
2A.2 Alienated Self-Image	50.4	31.8
2A.3 Vexatious Content	*70.7*	21.7
2B. Melancholic	55.8	27.9
2B.1 Cognitively Fatalistic	*70.5*	23.2
2B.2 Worthless Self-Image	53.8	34.8
2B.3 Temperamentally Woeful	54.9	30.0
3. Dependent	47.4	28.2
3.1 Expressively Puerile	59.6	23.8
3.2 Interpersonally Submissive	49.0	31.4
4A. Histrionic	54.7	23.4
4A.1 Expressively Dramatic	*67.5*	21.0
4A.2 Interpersonally Attention-Seeking	47.0	25.0
4A.3 Temperamentally Fickle	*65.4*	19.7

(Table 5 continues)

Table 5 (cont.)

MCMI-IV Scale and Subscales	M	SD
4B. Turbulent	61.7	22.6
4B.1 Expressively Impetuous	63.3	25.8
4B.2 Interpersonally High-Spirited	54.1	25.8
4B.3 Exalted Self-Image	61.6	21.6
5. Narcissistic	*72.4*	19.2
5.1 Interpersonally Exploitative	*65.8*	19.7
5.2 Cognitively Expansive	*62.8*	26.1
5.3 Admirable Self-Image	*70.9*	22.6
6A. Antisocial	76.9	11.9
6A.1 Interpersonally Irresponsible	60.5	23.4
6A.2 Autonomous Self-Image	*71.0*	15.8
6A.3 Acting-Out Dynamics	75.2	13.2
6B. Sadistic	61.7	23.4
6B.1 Expressively Precipitate	*73.3*	13.0
6B2. Interpersonally Abrasive	52.9	30.9
6B.3 Eruptive Architecture	52.1	29.9
7. Compulsive	52.0	17.6
7.1 Expressively Disciplined	59.6	21.4
7.2 Cognitively Constricted	58.0	21.4
7.3 Reliable Self-Image	47.4	21.4
8A. Negativistic	*66.3*	22.8
8A.1 Expressively Embittered	*69.6*	24.6
8A.2 Disconnected Self-Image	*65.2*	21.9
8A.3 Temperamentally Dysphoric	61.7	21.9
8B. Masochistic	54.5	26.3
8B.1 Underserving Self-Image	60.8	23.7
8B.2 Inverted Architecture	58.6	28.3
8B.3 Temperamentally Dysphoric	48.0	24.5
Severe Personality Pathology Scales		
Schizotypal (S)	*66.0*	17.8
S.1 Cognitive Circumstantial	58.7	21.5
S.2 Estranged Self-Image	58.8	21.8
S.3 Chaotic Content	*70.0*	19.6

(Table 5 continues)

Table 5 (cont.)

MCMI-IV Scale and Subscales	M	SD
Borderline (C)	54.7	29.9
Uncertain Self-Image (C.1)	45.7	31.5
Split Architecture (C.2)	57.6	28.1
Temperamentally Labile (C.3)	53.6	28.9
Paranoid (P)	*73.5*	21.3
P.1 Expressively Defensive	*68.9*	18.6
P.2 Cognitively Mistrustful	*71.6*	21.3
P.3 Projection Dynamics	*68.7*	24.9
Clinical Syndrome Scales		
Generalized Anxiety (A)	*74.3*	29.4
Somatic Symptom (H)	37.3	28.0
Bipolar Spectrum (N)	*70.0*	21.3
Persistent Depression (D)	49.0	30.5
Alcohol Use (B)	79.2	20.5
Drug Use (T)	**85.2**	17.4
Post-Traumatic Stress (R)	*66.8*	32.3
Severe Clinical Syndromes Scales		
Schizophrenic Spectrum (SS)	60.6	20.7
Major Depression (CC)	49.6	36.1
Delusional (PP)	*65.7*	21.0

Note. Italics indicates mean base rate scale scores 65-74, underline indicates mean base rate scales scores 75-84, bold indicates mean base rate scales scores 85 and above. All decimals have been rounded up to the nearest tenth decimal point.

Examination of the sample's mean scale and subscale scores presented in Table 5 showed one response style scale, nine clinical pattern scales, and 16 subscales had a mean base rate score in the 65 to 74 score range. The scales were Disclosure, Schizoid, Narcissistic, Negativistic, Schizotypal, Paranoid, Generalized Anxiety, Bipolar Spectrum, Post-traumatic Stress, and Delusional. They represented a broad range of personality characteristics extending from acting out and thought disorder features to those of emotional dysfunction. The subscales scores within this range included Interpersonally Unengaged, Meager Content, Vexatious Content, Worthless Self-Image, Expressively

Dramatic, Temperamentally Fickle, Interpersonally Exploitative, Cognitive Expansive, Admirable Self-Image, Autonomous Self-Image, Expressive Precipitate, Disconnected Self-Image, Chaotic Content, Expressive Defensive, Cognitive Mistrustful, and Projection Dynamics.

The mean base rate score for the Alcohol Use and Antisocial scales and the Acting-Out Dynamics subscale fell in the range of 75-85. Notably, the base rate mean score for the Drug Use scale exceeded the 85 range.

To investigate the first hypothesis of this study, biserial correlations were computed between the MCMI-IV Antisocial, Borderline, Histrionic, Sadistic, and Dependent disorder scales with substance use variables from the combined mental health screener. Results are shown in Table 6.

Table 6

Substance Use Correlates of MCMI-IV Scales

	Alcohol	Presence of Illicit Drug Use
Antisocial	-.028	-.033
Borderline	.016	-.050
Histrionic	.153	-.028
Sadistic	.004	.083
Dependent	.088	-.016

Alcohol and Drug Use, as reported by the sample, was shown to have no significant correlation with the Antisocial, Borderline, Histrionic, Sadistic, or Dependent scales. Hypothesis 1 was therefore not supported.

To investigate the second hypothesis of this study, biserial correlations were computed between the MCMI-IV Dependent, Melancholic, Schizoid, Compulsive, and

Negativistic scale scores with the suicide-related risk factor variables of the combined mental health screener. Results are shown in Table 7.

Table 7

Suicide-related Risk Factor Correlates of MCMI-IV scales

	Suicidal History	Intoxication	Depressed Mood	Plan to Harm Self	Critical Life Changes
Dependent	**-.44****	-.02	.21*	.17	.02
Melancholic	**-.45****	-.01	.10	.12	.11
Schizoid	-.10	-.01	.12	-.06	-.16
Compulsive	.20	.11	.03	.09	**.36**
Negativistic	-.21*	-.02	.11	-.01	.-09

Note. Correlation is significant at the .01 level (2-tailed). **
Correlation is significant at the .05 level (2-tailed). *
Bolded items hold an effect size of .30 or greater.

Among the correlates, history of suicidality was found to be negatively correlated with the Dependent, Melancholic, and Negativistic scale scores. The depressed mood risk factor was the only variable to be positively correlated with a MCMI-IV scale score, Dependent ($r_b = .21$, $p < .01$). Two of the significant correlations yielded a medium effect size of .30 or greater. However, the direction of the correlates are contrary to the hypothesis for the most part, and thus, hypothesis 2 was not confirmed.

The combined initial assessment and suicide risk assessment form was re-examined for inpatient treatment history, which was subsequently added to the correlational analysis. Results are shown in Table 8.

Table 8

Prior Inpatient Treatment Correlates of MCMI-IV scales

	Prior Inpatient Treatment
Dependent	**-.38****
Melancholic	**-.33****
Schizoid	-.26**
Compulsive	.17
Negativistic	-.22*

Note. Correlation is significant at the .01 level (2-tailed). **
Correlation is significant at the .05 level (2-tailed). *
Bolded items hold an effect size of .30 or greater.

Prior inpatient treatment was negatively correlated with the following scales: Dependent, Melancholic, Schizoid, and Negativistic. Two of the significant correlations met an effect size of .30 or greater. In summary, all significant suicide-related risk factors and inpatient treatment correlates of MCMI-IV scales shown in Table 7 and Table 8 were inversely correlated, contrary to the predictions.

Frequency data was computed for the suicide-related variables and inpatient treatment history obtained from the mental health screener to further explain these results. Results are shown in Table 9.

(continues)

Table 9

Frequency statistics for Suicide-related Factors and Inpatient Treatment History for the Total Sample (n=95)

Mental Health Screener Variables	n	%
Prior Suicidality		
Yes	32	33.7%
No	63	66.3%
Intoxication		
Yes	70	73.7%
No	25	26.3%
Depressed Mood		
Yes	43	45.3%
No	52	54.7%
Plan to Harm Self		
Yes	5	5.3%
No	90	94.7%
Critical Life Changes		
Yes	26	27.4%
No	69	72.6%
Inpatient Treatment History		
Yes	33	34.7%
No	62	65.3%

As seen in Table 9, the majority of participants did not endorse suicide-related factors or prior inpatient treatment history on the mental health screener with the exception of high intoxication-related risk. The low frequency of such risk factors within the sample may explain the nonsignificant correlation findings with the hypothesized MCMI-IV scales.

Hypothesis 3 compared MCMI-IV scores of the violent and non-violent groups on Antisocial, Sadistic, and Borderline scale scores. Means and standard deviations of each group are shown in Table 10 for the full set of MCMI-IV scales.

Table 10

MCMI-IV score Means and Standard Deviations for Violent versus Non-violent Sample (N=95)

MCMI-IV Scale and Subscales	Violent Offenders (n = 53)		Nonviolent Offenders (n = 42)	
	M	SD	M	SD
Response Styles				
Disclosure	*73.1*	15.8	*72.3*	14.7
Desirability	63.2	18.2	57.5	20.1
Debasement	58.8	24.2	61.3	18.4
Clinical Personality Patterns				
1. Schizoid	75.8	10.5	78.2	13.5
1.1 Interpersonally Unengaged	*68.5*	18.1	54.6	24.6
1.2 Meager Content	50.1	28.3	54.6	24.6
1.3 Temperamentally Apathetic	62.2	25.2	62.4	24.5
2A. Avoidant	60.3	26.1	60.3	26.6
2A.1 Interpersonally Aversive	60.8	23.0	*65.1*	23.0
2A.2 Alienated Self-Image	49.7	33.1	51.1	30.1
2A.3 Vexatious Content	*71.4*	20.8	*69.8*	22.9
2B. Melancholic	55.1	9.8	56.7	25.8
2B.1 Cognitively Fatalistic	*70.5*	24.8	*70.5*	23.2
2B.2 Worthless Self-Image	54.1	34.8	53.3	35.2
2B.3 Temperamentally Woeful	52.2	32.7	58.2	26.1
3. Dependent	46.9	28.3	47.9	28.4
3.1 Expressively Puerile	57.9	26.1	61.6	19.8
3.2 Interpersonally Submissive	47.3	31.3	51.2	31.9
3.3 Inept Self-Image	48.1	30.1	55.8	25.0
4A. Histrionic	55.9	23.4	53.1	23.6
4A.1 Expressively Dramatic	*71.4*	17.1	62.7	24.5
4A.2 Interpersonally Attention-Seeking	45.6	26.2	48.7	23.7
4A.3 Temperamentally Fickle	*68.5*	16.2	61.7	23.0

(Table 10 continues)

Table 10 (cont.)

MCMI-IV Scale and Subscales	Violent Offenders (n = 53)		Nonviolent Offenders (n = 42)	
	M	SD	M	SD
4B. Turbulent	*65.2*	21.3	57.4	23.7
4B.1 Expressively Impetuous	*66.4*	24.1	59.4	26.4
4B.2 Interpersonally High-Spirited	55.2	26.2	52.7	25.5
4B.3 Exalted Self-Image	63.7	20.1	59.1	23.3
5. Narcissistic	75.5	17.8	*68.5*	20.2
5.1 Interpersonally Exploitative	*68.9*	16.2	62.1	22.8
5.2 Cognitively Expansive	*67.5*	22.3	57.0	29.2
5.3 Admirable Self-Image	*71.9*	23.6	*69.6*	21.6
6A. Antisocial*	75.8	10.5	78.2	13.5
6A.1 Interpersonally Irresponsible	*65.1*	16.0	54.9	29.2
6A.2 Autonomous Self-Image	*69.0*	15.5	*73.4*	16.1
6A.3 Acting-Out Dynamics	*72.5*	14.7	78.4	10.2
6B. Sadistic*	60.2	24.0	63.5	22.6
6B.1 Expressively Precipitate	*72.9*	14.2	*73.7*	11.5
6B2. Interpersonally Abrasive	52.9	30.8	53.1	31.4
6B.3 Eruptive Architecture	48.4	32.4	56.6	26.2
7. Compulsive	54.7	17.7	48.7	17.2
7.1 Expressively Disciplined	61.1	20.8	57.8	20.9
7.2 Cognitively Constricted	58.9	20.9	56.9	22.6
7.3 Reliable Self-Image	49.4	20.4	45.0	22.7
8A. Negativistic	64.8	24.2	*68.0*	21.1
8A.1 Expressively Embittered	*69.9*	25.2	*69.2*	24.1
8A.2 Disconnected Self-Image	63.4	24.5	*67.4*	18.4
8A.3 Temperamentally Irritable	58.6	28.2	*65.4*	20.1
8B. Masochistic	52.5	26.9	56.8	25.5
8B.1 Underserving Self-Image	60.9	24.4	60.8	23.1
8B.2 Inverted Architecture	53.6	31.3	64.6	23.0
8B.3 Temperamentally Dysphoric	45.4	26.3	51.0	22.0

(Table 10 continues)

Table 10 (cont.)

MCMI-IV Scale and Subscales	Violent Offenders (n = 53)		Nonviolent Offenders (n = 42)	
	M	SD	M	SD
Severe Personality Pathology Scales				
Schizotypal (S)	*65.3*	19.6	*66.8*	15.5
S.1 Cognitive Circumstantial	57.5	23.5	60.2	19.0
S.2 Estranged Self-Image	56.4	23.9	61.6	18.9
S.3 Chaotic Content	*71.8*	18.2	*67.9*	21.3
Borderline (C)*	52.8	32.5	57.1	26.7
Uncertain Self-Image (C.1)	43.3	32.6	48.5	30.3
Split Architecture (C.2)	56.1	28.8	59.3	27.5
Temperamentally Labile (C.3)	52.8	30.7	54.5	26.8
Paranoid (P)	*73.3*	23.4	*73.7*	18.8
P.1 Expressively Defensive	*70.8*	18.2	*66.4*	19.0
P.2 Cognitively Mistrustful	*71.0*	23.1	*72.4*	19.2
P.3 Projection Dynamics	*67.0*	28.7	*70.7*	19.3
Clinical Syndrome Scales				
Generalized Anxiety (A)	*73.3*	30.7	75.5	27.9
Somatic Symptom (H)	36.5	28.1	38.3	28.2
Bipolar Spectrum (N)	72.5	20.5	*66.9*	22.1
Persistent Depression (D)	47.7	30.5	50.6	30.7
Alcohol Use (B)	77.4	19.7	81.4	21.4
Drug Use (T)	83.2	18.0	**87.6**	16.6
Post-Traumatic Stress (R)	64.8	32.9	*69.2*	31.8
Severe Clinical Syndromes Scales				
Schizophrenic Spectrum (SS)	60.9	21.8	60.1	19.6
Major Depression (CC)	50.5	36.3	48.4	36.2
Delusional (PP)	64.3	22.6	*67.5*	18.9

Note. * Scales of focus for comparison. Italics indicates mean base rate scale scores 65-74, Underline indicates mean base rate scales scores 75-84, Bold indicates mean base rate scales scores 85 and above. All decimals have been rounded up to the nearest tenth decimal point.

Although many of the base rate mean scores for the primary scales were high, results from the MANOVA analysis indicated no significant differences between the two

groups on the MCMI-IV. Specifically, there were no significant differences in scores on the Antisocial, Sadistic, and Borderline scales. A post-hoc exploratory analysis examined group differences in scores on all MCMI-IV scales to discern if there were alternative patterns of differences than those hypothesized. Results showed no significant differences in the 12 Clinical Personality Patterns and three Severe Personality Pathology scales base rate mean scores of the violent and nonviolent subgroups (Wilks' Lambda = .86, $F(15, 79) = 0.83$, $p = .65$, partial $\eta 2 = .14$). Furthermore, a univariate analysis of the aforementioned scales showed no significant differences between the two subgroups. Additionally, there were no different group differences in the seven Clinical Syndrome scales and the three Severe Clinical Syndrome scale scores (Wilks' Lambda = .86, $F(10, 84) = 1.36$, $p = .21$, partial $\eta 2 = .14$). Univariate analyses also showed nonsignificant results for the comparison between the two subgroups on the Clinical Syndrome and Severe Syndrome scales. Thus, Hypothesis 3 was not confirmed at the scale level.

The MANOVA comparing the two groups' base rate mean scores of the 36 Clinical Personality Pattern and the 9 Severe Personality Pathology subscales showed a significant group difference in scores (Wilks' Lambda = .39, $F(45, 49) = 1.68$, $p < .05$, partial $\eta 2 = .61$). Specifically, univariate analyses showed that violent and non-violent categorization had a statistically significant effect on the Expressively Dramatic ($F(1, 93) = 4.18$; $p < .05$; partial $\eta 2 = .04$), Interpersonally Irresponsible ($F(1, 93) = 4.66$; $p < .05$; partial $\eta 2 = .20$), Acting-Out Dynamics ($F(1, 93) = 4.99$; $p < .05$; partial $\eta 2 = .50$), and Cognitively Expansive ($F(1, 93) = 3.95$; $p = .05$; partial $\eta 2 = .41$) mean base rate scores. Except for Acting-Out Dynamics, mean scores were significantly higher in the violent group. The Expressively Dramatic subscale falls within the Histrionic scale,

Interpersonally Irresponsible and Acting-Out Dynamics subscales fall within the Antisocial scale, and the Cognitive Expansive subscale falls with the Narcissistic scale. Hypothesis 3 was minimally confirmed at the subscale level.

Discussion

Florida ranks as one of the highest states for the most incarcerated individuals within the United States. Of this population, both national statistics and psychological research indicate that the majority of inmates experience mental health problems during their incarceration (National Alliance on Mental Illness, 2006; BJS; 2016). Prior research has been instrumental in illuminating personality characteristics that inform the field's understanding of psychological dysfunction and behavioral maladaptation of offenders in a correctional setting. These characteristics include inmates' proclivity towards substance dependence, violent offending, and institutional maladjustment, which includes suicide, rebellion, self-mutilation, incident reports, and resistance (Kelln et al., 1998; Dozois & Kelln, 1999; Falotico, 2003).

Personality assessment is an ever-evolving specialty of psychology with increased application in correctional settings. As such, the evolution of personality assessment frequently calls for continued research in all clinical arenas, including specific populations such as incarcerated individuals. With the trend of increasing rates of incarceration in Florida, identifying characteristics and psychological dysfunction has become of greater importance. Personality instruments, such as earlier versions of the MCMI, PAI, and MMPI have been extensively used and fruitful in forensic research and versions of the MCMI are among the most commonly used assessment instruments intended to evaluate the psychological makeup of offenders. However, forensic research utilizing the most recent version, the MCMI-IV, remains underdeveloped. Given the recent release of the MCMI-IV, research on this test is still in its initial stages and no research on its use with inmates has yet to be published. Thus, it would be of value to

gain insight on inmate's personality characteristics using the newest edition of the MCMI and evaluate the results in comparison to prior research. Furthermore, prior MCMI research has not utilized additional instruments, such as a mental health screener, to develop correlates of MCMI scores. The intention of the current study was to lay the foundation for such research. This study aimed to provide initial reference data of MCMI-IV scores of jail inmates, expand the measured descriptions of MCMI-IV scales, and compare test profiles of violent and nonviolent inmates.

The first hypothesis of the current study was based on prior research utilizing earlier versions of the MCMI that assessed for emerging personality clusters among inmate substance users. It was predicted that substance abuse variables from the mental health screener would be positively correlated with the following MCMI-IV scale scores: Antisocial, Borderline, Histrionic, Sadistic, and Dependent. However, the current study did not demonstrate any significant correlations between substance abuse variables of the local jail's mental health screener and the MCMI-IV scales. These results are incongruent with prior research Craig, 1997; Chantry & Craig, 1994; Kelln et al., 1998; Matano et al., 1994). The current study's negative findings in this regard could be due to aspects of the mental health screener. Specifically, substance abuse variables in this screening instrument were coded dichotomously for the presence or absent of substance use prior to incarceration. This categorization method was restricting in that it did not sufficiently account for the type, intensity, or duration of use. Thus, participants' level of substance use and dependency remained unaccounted for and was not well distinguished between participants. It should be noted that the sample's mean scale scores for the Drug Use and Alcohol Use scales were higher than the clinical cutoff score of 75, suggesting clinical

significance. Similarly, research conducted by Dozois and Kelln (1999) found two emerging factors based on the variances in participants' responses utilizing the MCMI-III – one of which was the Substance Dependence factor, including Alcohol and Drug Dependence scales. Other researchers have also found concerns with drug and alcohol use with the inmate population that have commonly been correlated with MCMI high scale scores on scales that assess for personality characteristics such as engaging duplicitous behavior, relying on external factors to maintain a sense of wellbeing, and unyieldingly seeking personal pleasure (Kelln et al., 1998; Matano et al., 1994). In regards to the current study, the incongruence between high mean scores of the substance use-related scales and the nonsignificant correlations found with the mental health screener may be attributed to the questionable level of candid disclosure on the part of the inmates at the time the mental health screening was conducted, ultimately weakening the correlations between mental health screener variables and the MCMI-IV scale scores. Although meaningful substance abuse correlates on the MCMI-IV scales were not found in the present study, drug and alcohol use remain a concern for the inmate population and should continue to receive attention in future research.

The second hypothesis of this study predicted suicide-related factors would be positively correlated with high MCMI-IV scores on the Dependent, Melancholic, Schizoid, Compulsive, and Negativistic scales. Although this had not been directly studied in prior research, this hypothesis was driven from prior research with the PAI and the MCMI-III as well as the scale descriptions of the MCMI-IV. There were no significant correlates shown of the selected MCMI-IV scale scores in relation to the screener variables. In fact, there were three negative correlations found between the

suicide-related variables on the screener and scale scores. Similarly, the inpatient treatment were not in the predicted direction. In fact, they were in the inverse direction. It should be noted that, in the current sample, over 65% of the participants reported having no prior inpatient treatment, as well as no prior suicidality, which is likely to have had an impact on the results. Overall, there was limited data supporting high MCMI-IV scores would be correlated with variables identified on the mental health screener, such as substance use and suicide-risk factors.

The third, and final, hypothesis of this study predicted offenders with violent histories would likely produce higher mean scores on the following MCMI-IV scales in comparison to their non-violent offending peers: Antisocial, Sadistic, and Borderline scales. In the current study, no significant differences were found at the MCMI-IV scale level in regards to any of the aforementioned scales. However, there were some significant differences noted at the subscale level in a post-hoc exploratory analysis. Notably, there were significant differences found on the Expressively Dramatic, Interpersonally Irresponsible, and the Cognitively Expansive subscales in the direction of higher scores for violent offenders. These findings suggest violent offenders have a tendency to engage in a volatile, overreactive manner with a low level tolerance for frustration. Likewise, they suggest that violent offenders spend considerable effort in fueling preoccupations that are self-glorying and tend to disregard duties and responsibilities. On the other hand, mean scores on Acting-Out Dynamics facet scale were significantly higher in the non-violent group than the violent group. This finding is particularly puzzling as violent behavior is typically construed as a form of acting-out. The Acting-out Dynamics subscale assesses the dynamic of tension release through

harmful verbal and physical actions expressed without forethought and usually not accompanied with guilt and remorse. High scales scores are associated with a self-view as a victim, and therefore, maintaining a disregard for one's own actions and others' wellbeing. It is noted that, of the 53 violent offenders included in this study, 37 of the inmates had prior incarcerations. One could conclude that the violent offenders within this sample are routine offenders rather than impulsive offenders and such violent acts may be calculated and well-thought out rather than unconstrained.

Overall, the findings derived from this study were somewhat limited in scope and may not be an adequate representation of the utility of the MCMI-IV in assessing an inmate population. There are a few possibilities to consider in this regard. The first consideration is that the hypotheses developed for this study were derived from prior research, some of which utilized a different assessment measure, or were derived from scale descriptions due to a lack of prior research findings to guide the current study. The current study's hypotheses could therefore have been misdirected. However, this consideration likely had the least impact on the current study's results, given the established convergent validity of the MCMI-IV with other personality measures. Another consideration is the study's sample. As mentioned earlier, the sample largely did not endorse variables on the mental health screener that would have produced meaningful correlations with the MCMI-IV scale scores. This also suggest that the obtained sample may have had different mental health difficulties than substance abuse or suicide, and the presence, acuteness, or chronicity of such mental health problems were not assessed in this study. Future research with a focus on specific, rather than broad, mental health problems may be warranted to eliminate the issue of symptom frequency endorsement in

order to develop correlates. The final consideration relates to the application of the mental health screener, its degree of subjectivity and variability among mental health professionals within the jail, and its mode of administration. This consideration is further outlined in the limitations of this discussion. Overall, the lack of frequency of endorsed symptoms within the sample and the administration of the mental health screener, collectively, are the most plausible constraints to the current study and its results.

The current research, although limited in its findings, is the first of its kind. MCMI-IV research remains underdeveloped at this time; however, the current study can provide direction for future research to be conducted utilizing this relatively new instrument. The study provided reference data based on a sample of jail inmates, revealing high mean scores on several MCMI-IV scales. Additionally, the current study was also the first of its kind to utilize variables obtained from a mental health screener to identify correlates between the two instruments, and to attempt to distinguish between violent and nonviolent offender MCMI-IV scores.

The current study had several limitations. First, although a reasonable sample size was obtained, the studied sample represents only a small portion of inmates seen for mental health services at the jail. The findings therefore have limited generalizability to the overall population of mental health-referred inmates within the Brevard County jail and United States' correctional institutions at large. Additionally, the sample size was further reduced in the comparison of violent and nonviolent subgroup scores, which likely prevented detection of meaningful patterns. Another point to consider, particularly in regards to hypothesis 3, is that a large portion of inmates included in this study had received multiple charges; thus, the subgroupings of violent and non-violent offenders

was not mutually exclusive. For the purpose of this study, violent classification was determined by the presence of being charged with at least one violent criminal act against another person. However, many classified violent offenders in this study also obtained additional non-violent charges, further limiting the specificity of comparison between violent and non-violent offenders. The limited sample size also presented concerns for the participant to variable ratio. The far from optimal ratio likely resulted in loss of statistical power, such that some significant findings may have been obscured.

Finally, the present study highlights concerns for examining MCMI-IV correlates with self-report data derived from face-to-face interactions, such as the information obtained on the mental health screener, as the degree of disclosure may ultimately prevent producing meaningful results. The mental health screener used in the local jail is conducted in an interactive format between the inmate and the mental health professional. Research has shown inmates have a tendency to limit their disclosure regarding intimate topics (Cozby, 1973). Possible motivations for inmates to limit their disclosure on the mental health screener may have included attempts to influence their housing placement within the jail, to avoid being placed on a suicide watch, or to avoid detox monitoring and housing - all of which result in greater supervision when compared to placement in the general population. It should be noted that the original intent of this study was to use an additional broadband test, such as the MMPI-2-RF. However, institutional constraints prevented the administration of more than one broadband measure. These constraints included inmate scheduling, availability of security staff during the test administration periods, and room availability.

Further research is warranted at this time, given the recency of the newest edition of the MCMI, to expand upon the current research. Factors to consider in future research include, but are not limited to the following: 1) a larger sample size; 2) a broader sample obtained from multiple institutions; and 3) the use of standardized instruments with known reliability and validity to establish correlates of MCMI-IV scale scores. Future research may also be directed towards developing specific norms for the MCMI-IV relevant to forensic samples. National sampling would be useful for examining profile patterns of incarcerated individuals at a larger scale and would inform the development of norms that can be generalized across the United States. Continued research directed at identifying profile patterns would be advantageous for establishing what a common profile for inmates might look like, thereby increasing the utility of the instrument in forensic settings, particularly in informing treatment and placement decisions. Additional research comparing violent and non-violent samples would also be worthwhile for guiding policies concerning the safety of individuals incarcerated in U.S. jails.

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Appendix A

Informed Consent Form

Please read this consent document carefully before you decide to participate in this study. The researcher will answer any questions before you sign this form.

Title: Millon Clinical Multiaxial Inventory-IV (MCMI-IV) Profile Patterns and Scale Score Correlates for Jail Inmates Referred for Mental Health Services

Researcher: Lauren, Doctoral Student, Florida Institute of Technology

Purpose. This research study is being conducted by Lauren for her clinical doctoral research project at the Florida Institute of Technology under the direction of Dr. Krishnamurthy. The purpose of this study is to build the research on a recently developed clinical assessment tool - the Millon Clinical Multiaxial Inventory-IV (MCMI-IV) - in terms of its use with inmates referred for mental health services.

Procedures. If you decide to participate in this study, you will be asked to fill out a personality questionnaire, the MCMI-IV. The assessment will take approximately 45 minutes to complete. Additionally, some information about you will be collected from your mental health file for this study, but you will not identified by your information.

Risks. There are no expected risks from your participation in this study. However, should you experience discomfort due to your participation, please contact the Mental Health Unit at the Brevard County Jail Complex.

Benefits. Your participation in this study will contribute to the research on a new personality test and will assist mental health professionals in better understanding the psychological characteristics of the inmate population.

Compensation. There will no direct compensation offered for participation in this study.

Confidentiality. Your identity will be kept confidential to the extent provided by law. Your information will be assigned a code number, instead of any personally identifying information. The list connecting your name to this number will be kept in a locked file. When the study is completed and the data has been analyzed, the list will be destroyed. Your name will not be used in any report.

Voluntary Participation: Participation in this study is voluntary, and there will be no penalty for not participating. You have the right to withdraw from the study at any time without consequence.

Participant's Agreement. I have read the above information. The study has been explained to me and my questions have been answered by the primary researcher of this study. My signature below indicates that I am voluntarily agreeing to participate in this study.

_____

Participant Name (Printed) Signature Date

Witness Statement. I can attest that all information has been accurately conveyed to the participant as outlined above.

_____

Name of Witness (Printed) Signature Date

_____

Researcher Name (Printed) Signature Date

Date In: Date Out:

Brevard County Jail Complex
Mental Health Unit
Combined Initial Assessment and Suicide Risk Assessment

Name: _____ DOB: _____ Race: _____ Sex: _____
Date: _____ Time: _____ Loc: _____ CID#: _____
Current Charges: _____
Previous Incarceration: ☐ N ☐ Y Date (s): _____
Reason for Referral: _____

Veteran Status ☐ N ☐ Y Branch of Service _____ Years in Service _____ Type of Discharge _____

I. Social History and Family History

1. Educational History _____
2. Learning Disability/MR ☐ N ☐ Y _____
3. Employment History _____
   a. Disabled ☐ N ☐ Y _____
4. Living Arrangement _____
   a. History of Homelessness _____
   b. Housing Plan after Arrest _____
   c. Contact Person & Info _____
   d. Social Support: _____
5. Family Psych History ☐ N ☐ Y _____
6. Marital Status/Significant Other: ☐ Married ☐ Divorced ☐ Widowed(er) ☐ Single ☐ Stable ☐ Troubled
7. Financial Status: ☐ Stable ☐ Unstable _____

II. Psychiatric & Medical History

Allergies: _____

1. Previous Psychiatric ☐ N ☐ Y _____
2. Inpatient Treatment ☐ N ☐ Y _____
3. Psychotropic Medications ☐ N ☐ Y Current Rx _____ Compliance ☐ N ☐ Y
4. Sleep or Eating Disorders ☐ N ☐ Y _____
5. Energy Level ☐ Low ☐ Agitated ☐ Lethargic ☐ Fatigue ☐ Animated
6. Medical Problems ☐ N ☐ Y ☐ Acute ☐ Chronic _____
   a. Head Injury ☐ N ☐ Y _____
   b. Seizures ☐ N ☐ Y _____ Date of Last Seizure: _____
   c. Terminal ☐ N ☐ Y _____
   d. Recent Diagnosis ☐ N ☐ Y _____
7. Abuse Hx ☐ Physical ☐ Sexual _____
8. Are you having any current issues related to this abuse: ☐ N ☐ Y _____

III. Alcohol & Drug Dependence Involvement

1. Substance Abuse History ☐ N ☐ Y _____
   ☐ Alcohol ☐ Cocaine ☐ Marijuana ☐ Heroin ☐ Benzodiazepines ☐ Methamphetamine ☐ Opiates ☐ Ecstasy ☐ Other
   Specific type and route _____
2. Recency of Use ☐ N ☐ Y _____
3. Withdrawal History ☐ N ☐ Y _____
4. Prior Substance Treatment ☐ N ☐ Y _____
5. Family Hx of Subst. Abuse ☐ N ☐ Y _____

IV. Violence History / Risk

1. Assault/Battery Arrest Hx ☐ N ☐ Y ☐ Victim ☐ Perpetrator _____
2. Domestic Violence Hx ☐ N ☐ Y _____
3. Homicidal Ideation ☐ N ☐ Y Recency _____ Intent _____
4. Unusual Risk for Victimization _____

V. Suicidal Ideations & History

1. Hx of Suicide Ideation Attempt ☐ N ☐ Y _____
   a. # of Prior Acts _____ Recency: _____
   b. Triggering Stimuli _____ Treatment Received: _____
   c. Identified Secondary Gain/Motive _____
2. Suicidal Ideation ☐ N ☐ Y _____
   a. Plan ☐ _____
   b. Availability ☐ _____
   c. Lethality ☐ _____
   d. Current Intent ☐ _____
3. Protective Factors
   a. Coping Strategies _____
   b. Awareness of Available Social Support ☐ N ☐ Y _____
   c. Resolution of Triggering Stimuli _____
   d. Suicide as Ego Dystonic ☐ N ☐ Y _____
   e. Plan to Deal w/Suicidal Thoughts ☐ N ☐ Y _____
   f. Stated Purpose for Living ☐ N ☐ Y _____
   g. Hope Factors ☐ Children ☐ Family ☐ Career ☐ Future Plans & Goals ☐ None
   h. Inhibiting Factors ☐ Religion ☐ Family ☐ Reputation ☐ None
4. Risk Factors
   a. Strong Sense of Guilt/Shame/Failure ☐ N ☐ Y _____
   b. Unresolved Precipitating Problem ☐ N ☐ Y _____
   c. Current Plan to Harm Self ☐ N ☐ Y _____
   d. Severely Depressed Mood ☐ N ☐ Y _____
   e. Intoxication ☐ N ☐ Y _____
   f. Critical Life Changes ☐ N ☐ Y _____
   g. Suicide as Ego Syntonic ☐ N ☐ Y _____
   h. Active Psychosis ☐ N ☐ Y _____
   i. Hopeless/Helpless/Worthless ☐ N ☐ Y _____
   j. Problems related to Incarceration ☐ N ☐ Y _____
   k. Possible Vulnerability in Jail Setting ☐ N ☐ Y _____
   l. Unrealistic View of Legal Status ☐ N ☐ Y _____

Mental Health Status Summary

Orientation: ☐ Person ☐ Place ☐ Time ☐ Situation

Affect/Mood: ☐ Euthymic ☐ Euphoric ☐ Frightened ☐ Manic ☐ Angry
☐ Labile ☐ Anxious ☐ Blunted ☐ Depressed ☐ Flat
☐ Dysphoric ☐ Tearful ☐ Hostile ☐ Uncooperative ☐ Withdrawn
☐ Low Energy/Fatigue ☐ Alert ☐ Cooperative ☐ Pleasant

Behavior: ☐ Psychomotor Retardation ☐ Physical Aggression ☐ Verbal Aggression
☐ Psychomotor Agitation ☐ Hostile ☐ Cooperative

Thought Pattern: ☐ Disorganized ☐ Hallucinations (specify) _____
☐ Ideas of Reference ☐ Confused ☐ Grandiosity ☐ Shame ☐ Concrete

Speech: ☐ Paranoia ☐ Delusional ☐ Coherent Thought Processes
☐ Soft ☐ Rapid ☐ Loose Associations ☐ Loud ☐ Pressured
☐ Circumstantial ☐ Limited Verbalization ☐ Slowed ☐ Incoherent ☐ Flight of Ideas
☐ Tangential ☐ Irrelevant ☐ Word Salad ☐ Lucid ☐ Relevant ☐ Coherent

HOUSING / WATCH STATUS

☐ **Direct Watch** ☐ **15-Minute Watch** ☐ **Medical Pod** ☐ **MH Pods** ☐ **GP**

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Rating Scale: _____

RECOMMENDATIONS

Psych F/U _____ **MH F/U** _____

Housing _____ **Referrals to** _____

Observations

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Interviewer _____ **Date** _____

Release to Jail Oversight: _____

Release to P.T.R. _____