ASSESSING SUBSTANCE ABUSERS WITH THE MILLON CLINICAL MULTIAXIAL INVENTORY (MCMI)

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By

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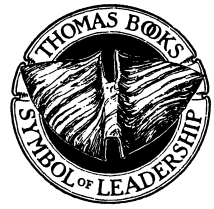

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PREFACE

The construct validity of a psychological test is assessed by what is referred to as a multitrait-multimethod nomothetic matrix (Campbell & Fiske, 1959). Essentially, this means that the psychometric properties of an assessment instrument are studied with a variety of populations and in a variety of settings and weighed against a variety of other measures that purportedly assess the same construct. This concept implies that a test might be useful with some kinds of populations but not with others. It implies that a test can have strong validity for one group but weak validity with another group. This is the idea behind this book. In order to add to the construct validity of the Millon Clinical Multiaxial Inventory (MCMI), evidence is presented on the psychometric properties of this test with both alcohol and drug abusers.

Substance abuse is endemic in our society and creates a number of difficulties for both the individual and society. Some of the costs associated with substance abuse are presented in Chapter I along with the extent of the problem. The need for early diagnosis and intervention is apparent. Unfortunately, accompanying a substance use disorder are denial and rationalizations as primary defense mechanisms designed to maintain the drinking and drugging. This means that simply asking a patient if he or she has a problem with alcohol or drugs is likely to evoke minimizations and outright lies in order to avoid detection and to maintain the behavior. Accordingly, many objective measures have been developed to address the substance abuser's denial of the problem.

Psychologists who develop omnibus personality inventories have felt obligated to include scales that assess alcohol and drug abusing tendencies. While some, such as the Inwald Personality Inventory or the Addiction Admission Scale of the Minnesota Multiphasic Personality Inventory–2 (MMPI–2), simply ask the patient to report whether he or she has a problem with alcohol or drugs, most have scales that assess these disorders more indirectly. Such scales include the MacAndrews

Alcoholism Scale and the Addiction Potential scale from the MMPI–2, or the addiction scales from the Personality Assessment Inventory. Even personality tests in development, such as the Emotional Assessment Survey, currently under development by James Choca, Ph.D., and colleagues at Roosevelt University, Chicago, have scales that measure substance abuse.

The MCMI has two scales that assess alcohol abuse and drug abuse, both directly and indirectly. This is more fully explained in Chapters III and IV, along with the psychometric properties of these scales and ways they have been used to detect substance abuse and to assess substance abusers. In addition to these scales are code types or aggregate group profiles associated with having a substance abuse problem. If it can be shown that a common profile underlies these conditions, this will assist those who develop computer-interpretive narratives for test interpretation. And this will assist clinicians to better understand their clients, because a unique feature of the MCMI is Millon's theory that links a clinical syndrome with their underlying personality disorder.

Chapter II presents an overview of Millon's theory of personality and a description of the development and standardization of the MCMI. Chapter V integrates the research findings presented in Chapters III and IV and the chapter concludes with directions for future research. Researchers and clinicians interested in this area of mental health may want a more detailed description of any particular article that used the MCMI with alcoholics or drugs addicts. Therefore the concluding chapter of this volume presents an annotated bibliography of all studies conducted with substance abusers using the MCMI.

Throughout these chapters, in many places, I use the terms alcohol abuse, alcohol dependence, drug abuse, drug dependence, substance abuse, and problematic use interchangeably. Although official diagnostic criteria (i.e., DSM) makes a distinction between many of these terms, researchers have not always attended to the official nomenclature when phrasing their reports. However, in almost all cases, patients had manifestations of the disorder severe enough to require treatment, either inpatient or outpatient, and hence had met abuse if not dependence criteria. The exception to this is when I describe the population studied and tried to maintain the terminology used by the author(s).

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Chapter I

EPIDEMIOLOGY OF SUBSTANCE ABUSE

Sources of Data on Prevalence

Epidemiology may be defined as the study of the incidence and prevalence of disease. Prevalence refers to the total number of cases in a defined period of time. The timeframe that is most often used is one year, but other timeframes are also reported in the literature, depending on the disease and the reason for or the purpose for which the report will be used. *Incidence* is the total number of new cases in a given time period. So, for example, the prevalence of heroin addiction is the sum of the prevalence of heroin addiction last year plus the incidence of heroin addiction for this year.

The government relies on a number of sources to determine the incidence and prevalence of substance abuse in the United States. After compiling this data (which is often delayed), we get a picture of the scope and severity of the problem; by comparing this data over time, we get a picture of trends of problematic substance use and abuse in our nation.

The following sources are the ones more commonly used for these purposes:

- ***Alcohol Sales:*** This is determined from the sale tax on alcohol products and gives a picture of the types (beer, wine, spirits) and amount of use over a given period of time. This variable is also useful in determining the effects of increased taxation on alcohol consumption.
- ***Population Surveys:*** These are a very common source of epidemiological information in the substance abuse field. Respondents are asked about their use patterns for various classifications of licit and illicit drugs. Of course, this method relies on the truthfulness of the respondent. The method also fails to capture abusers in jails,

hospitals, homeless shelters, and those who live on the street without permanent addresses. These surveys also tend to be costly and to underestimate the extent and severity of actual use for the reasons listed above.

- ***Death Records:*** Data is collected on alcohol-related mortality from three major sources: (1) death certificates that list alcohol as a contributing factor, (2) deaths from diseases associated with alcohol, and (3) fatal traffic accidents where a blood alcohol level has been obtained.
- ***Drug Abuse Warning Network (DAWN):*** This project tallies data from emergency rooms in twenty metropolitan cities. A form is sent in to the government by ER personnel whenever the visit is prompted by alcohol and drug abuse.
- ***Treatment Surveys:*** Most programs are required to fill out an annual report on the number of admissions and discharges along with primary drug of abuse, as well as multiple other kinds of data. This variable then taps abusers in treatment settings.
- ***Arrestee Urinalysis:*** This data emanates from police districts which test arrestee urine following the commission of a crime. The data is affected by police operations which periodically put more or less emphasis on drug-related crime based on local needs.
- ***Drug Seizures:*** When drugs are seized by local or federal officials, they are analyzed for purity levels. Costs on the street for these drugs are often publicized in the larger drug seizures. The analyses tell us the amount or availability of drugs within a community.
- ***Ethnographic Research:*** A variety of organizations and institutions collect data that are unique to a local community. These are then published in discipline-specific journals.
- ***National Household Survey:*** This telephone survey is taken annually and assesses those whose substance abuse primarily pertains to prescription drug abuse. This is often considered a hidden population and most often addresses prescription practices (and caused by?) of primary care physicians.
- ***High School Senior Survey:*** This is a largest data collection of its kind and has been conducted since 1975. Called "Monitoring the Future," researchers at the University of Michigan sample drug use patterns and prevalence among high school seniors, in sample sizes that are around 45,000 each year. It samples both attitudes towards and actual reported usage of a broad category of alcohol and drug use among eighth, tenth, and twelfth graders. While this survey misses

a key cohort of abuse–the school dropout–nevertheless it provides us with an excellent picture of attitudes and patterns of use during key developmental years.

For a more thorough presentation and discussion of this data, the reader is referred to various textbooks on substance abuse (Craig, 2004) and to government websites, especially those of the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse. Here we highlight only some of the prevalence data from some of the sources cited above. We look at the scope, severity, and costs of the substance abuse problem in the United States. The data clearly demonstrate that alcohol and drug abuse are serious problems, which require good assessment tools and adequate treatment for those in need.

Scope of the Problem

In the last "Monitoring the Future" data presentation, lifetime use of any illicit drugs in the past thirty days among teenagers was estimated to be 17%, for the past year prevalence was 28%, and lifetime use of any illicit drugs was 37%. For alcohol, 55% reported using alcohol during the past year and 33% reported using alcohol within the past 30 days (Monitoring the Future, 2003).

Hospital Visits

The most recent data on drug abuse related to hospital emergency room (ER) visits are from the Drug Abuse Warning Network (DAWN) for the year 2000. Alcohol in combination with other drugs was the most frequently mentioned drug at the time of admission to the ER (204,524), followed by cocaine (174,896), heroin/morphine (97,287), and marijuana (97,287). The most frequently cited motives for taking substances that precipitated the visit to the ER were dependence (36%), suicide (193,061 or 20%), and overdose (264,240 or 44%). Among inmates in federal prison, 67% are there for alcohol or drug-related offenses (www.samhsa.gov/statistics/statistics.html). Consider also the number of drunk drivers involved in fatal crashes (where often the victim dies, but the drunk driver survives), the amount of marital discord and domestic violence and other crimes related to substance abuse, the number of alcohol- and drug-related medical problems associated with substance abuse and dependence and the costs associated