MCMI - III Profiles of Combat Veterans:

Predictors of Educational and Vocational Impairment

by

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A thesis submitted to the School of Psychology and the
Graduate School of Florida Institute of Technology
In partial fulfillment of
the requirements for the degree of
Master of Science in Psychology

Melbourne, Florida
July 1998
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MCMI-III Profiles of Combat Veterans: Predictors of Educational and Vocational Impairment

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ABSTRACT

Title: MCMI-III Profiles of Combat Veterans: Predictors of Educational and Vocational Impairment

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This study investigated the ability of four selected scales on the MCMI-III, Passive Aggressive, Avoidant, Antisocial and PTSD to determine the amount of variance contributed by each of the scales as predictors of educational and vocational impairment in Vietnam Veterans. Subjects consisted of 40 Vietnam veterans diagnosed with PTSD who received treatment at an outpatient Readjustment Program in Brevard County, Florida. Multiple Regression analyses identified the Passive-Aggressive personality scale on the MCMI-III as significantly contributing to the variance as a predictor in vocational impairment, however, in an unexpected direction. Results and implications of these findings are discussed.
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MCMI-III Profiles of Combat Veterans: Predictors of Educational and Vocational Impairment

Introduction

Although the Vietnam war concluded 23 years ago with the fall of Saigon in 1975, there is a sense it never ended. The experience continues to be felt by millions of Americans: by the families of those who died in Vietnam, by those who served in the war and returned home to be as much shunned as honored, and those who resisted the draft or demonstrated against the war until the nation became an ideological battlefield (Long, 1986).

Despite a difficult homecoming from a moral and military defeat, many Vietnam veterans were able to adjust well and assimilate into society. However, decades later the consequences of the psychological stress of combat can be seen in the readjustment, psychiatric and health problems endemic for those veterans who survived heavy combat. Research has indicated that veterans who were exposed to the heaviest degree of combat exposure reported significantly more psychological problems on a symptom checklist than did light combat victims (Fairbank, Keane, Malloy, 1983). Unfortunately, for some veterans who were asymptomatic and had delayed stress reaction symptoms, treatment from the VA was difficult to obtain because of a one year time limit after which the Veterans Administration would not recognize neuropsychiatric problems as service-connected (Goodwin, 98).
Furthermore, the symptoms which were characteristic of Vietnam Veterans were not recognized as a diagnostic category called PTSD until 1980, when the American Psychiatric Association created a diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM-III-R) for those who experienced traumatic events (APA, 1987 and Van Der Heyden, 1995). It is estimated that 30.9 percent of all male Vietnam theater veterans have had full-blown PTSD at some point in their lives and 26.9 percent of all female Vietnam theater veterans experienced PTSD at some time in their lives (Kulka, 1990).

The common associated symptoms of PTSD which include recurrent and intrusive recollections of the event; a persistent avoidance of stimuli associated with the event, and persistent symptoms of hyperarousal may adversely impact on the cognitive, emotional and behavioral components of PTSD victims. Further, victims of PTSD experience an estrangement from others and may demonstrate a diminished interest or participation in significant activities, all of which contribute to potentially dysfunctional interpersonal interactions which adversely effect occupational impairment.

Recent studies (Showalter, 1995; Van Der Heyden, 1995) have investigated the utility of the MMPI in assessing various coping resources and PTSD symptom severity as predictors of employment status in combat veterans. The current study
will investigate the utility of the Millon Clinical Multiaxial Inventory-III (MCMI-III) in assessing symptom severity as a predictive measure of educational and vocational impairment. Both Educational and Vocational Impairment in Vietnam Veterans will be rated from demographics obtained from self-report data obtained during the clinical interview.

Review of the Literature

Post Traumatic Stress Disorder

One of the first studies of PTSD in civilian life was investigated in the 1940's by Alexandria Adler, who examined the victims of the Coconut Grove fire disaster in a crowded nightclub which resulted in a large number of deaths. This report underscored the fact that symptoms of depression and anxiety associated with traumatic experience may be more persistent than was previously thought. Studies of Holocaust survivors followed and described the psychic and emotional numbing associated with trauma outside the realm of human experience (O'Brien, 1980).

It was not until World War I that specific clinical syndromes came to be associated with combat duty. American involvement with the Vietnam War also showed problematic symptoms of combat veterans. However, unlike the previous wars where there was a correlation of increased incidence of neuropsychiatric
disorder and combat intensity, the Vietnam experience proved different. Among
the Vietnam veterans neuropsychiatric symptoms were not a function of an
increase in combat intensity, rather clinical syndromes began to increase during
readjustment to civilian life (President's Commission on Mental Health). Although
the end of American troop involvement occurred in 1973, it wasn't until 1980 that
the American Psychiatric Association created a diagnostic category in the DSM III
which was called post-traumatic stress disorder, with additional specifiers of acute,
chronic and delayed.

Currently, PTSD is classified in the Diagnostic and Statistical Manual
(DSM-IV) as a disorder in which the essential feature is the development of a
characteristic symptom following a psychologically traumatic event that is
generally outside the range of human experience. Many of the symptoms are
varied and fall along a continuum of severity, however, they are classified into
three categories: 1) reexperiencing the traumatic event through flashbacks,
nightmares, 2) avoidance of the stimuli that reminds the person of the traumatic
event which would include thoughts and feelings associated with the event, and 3)
an increased level of arousal after the traumatic event which may impair
concentration and memory.
Vietnam Combat Veterans and PTSD

Epidemiological facts about PTSD claim that 15.2 percent of all male Vietnam theater veterans (479,000 out of 3,140,000 men who served in Vietnam) are current cases of PTSD. Furthermore, 8.1 percent of all female Vietnam theater veterans (610 out of 7,200 women who served in Vietnam) are current cases of PTSD (National Center for Post-Traumatic Stress Disorder). Research has indicated the development of PTSD symptom severity is related to combat intensity. However, data support the notion that the type of trauma experienced by an individual as well as the amount contributes to the severity of PTSD symptoms (Yehuda, Southwick, and Giller, 1992). While PTSD symptoms were associated with exposure to combat, level of combat was related to pre-military factors such as socioeconomic status and high school experience. Individuals from a lower socioeconomic status who did not have the ability or access to academic achievement were more likely to enlist in the military and be sent to Vietnam. Those who experienced high levels of combat were more likely to have PTSD symptoms as long as 10 years after their return (Codray, Polk, and Britton, 1992).

Additional factors influencing PTSD depend on the interactive effect of premorbid, comorbid, and postmorbid personality factors and social support. Data support that the Self Defeating Personality Style as measured by the MCMI-II scales indicated that this personality style tended to experience increased PTSD
symptom severity and treatment difficulty (Hyer, Davis, Woods, and Albrecht, 1992).

Cognitive Functioning and Educational Impairment

Three cognitive changes are commonly found in patients with PTSD which include impaired memory, difficulty concentrating and difficulty associated with task completion (Wilmer, 1982). Many variables can effect adaptive functioning in relation to the cognitive skills required for new learning. Evidence has suggested that Vietnam Veterans with both PTSD and concurrent diagnoses of depression, anxiety, or substance abuse exhibited more impairment in cognitive functioning than did veterans without these diagnoses (Barrett, Green, Morris, Giles, and Croft, 1996). Furthermore, recent research has reported that Vietnam veterans with PTSD had an eight percent smaller right hippocampal volume than a group of comparison subjects Bremmer, Scott, Delaney, Southwick, Mason, Johnson, Innis, McCarthy, and Charney, 1993). The importance of the hippocampus in learning and memory has been demonstrated by neuroanatomical and neuropsychological studies and lesions of the hippocampus have been associated with deficits in short-term memory. In a recent study comparing short-term memory functioning in patients with combat-related PTSD and matched comparison subjects suggested that PTSD patients scored significantly lower on total recall, long-term storage, long-term
retrieval, and delayed recall measures for the verbal component of the Selective Reminding Test (Barrett, et al., 1996). Hopefully, these findings will have implications for educational remediation and compensation for cognitive impairment in veterans with PTSD.

**Millon Clinical Multiaxial Inventory-III**

The MCMI-III is an assessment instrument consisting of 24 scales that provides information on both personality styles and clinical syndromes. The scales are designated into four categories. The first ten scales assess clinical personality patterns and the next three modifying indices assess severe personality pathology. The following seven scales assess clinical syndromes, and the final three assess the severe syndromes.

Since personality disorders are not normally distributed, it is more desirable to convert raw scores based on the rate of the disorder in a population. The MCMI-III converts scores into Base Rate scores. Base Rate scores were developed based on prevalence data of Axis I disorders among 713 clinical patients in treatment and prevalence data of Axis II disorders among a representative national group of 937 patients with the disorder. A BR of 60 is at the median. A BR score of 75-84 is suggestive of the disorder being present while a BR score of >84 suggests the
syndrome is prominent. A BR >84 indicates that the individual has all the characteristics as defined by the disorder (Craig, 1993).

Research has indicated that most scales, except for the Compulsive and Passive-Aggressive scales, correlate fairly well with the corresponding disorder. Although the Passive-Aggressive scale has a low correlation to the passive-aggressive personality disorder, it has a high correlation to other disorders. An analysis of the hit rates show that the Avoidant and Dependent scales were best, whereas the Schizotypal, Histrionic, Borderline, Narcissistic and Paranoid scales were useful at the highest 84/85 cutoff point (Torgersen and Alnaes, 1990).

**Vietnam Combat Veterans and Employment**

The subtyping of combat veterans with PTSD syndromes on the basis of Axis II Personality Patterns may have implications with regard to vocational rehabilitation. Research suggests that diagnosis and vocational outcome are not necessarily correlated. Even though an individual may be given a specific diagnosis, there is little or no correlation between a person’s symptomatology and functional skills. However, a significant predictor of future work performance is a person’s ability to get along or function socially with others (Anthony and Jansen, 1984). Since the personality disorders are viewed as disturbances in enduring patterns of behavior that deviate from the expectations of an individual’s culture,
these maladaptive personality traits may contribute to interpersonal difficulties and the ability to perform optimally in some corporate cultures and climate. Therefore, what is relevant in employment situations is not the diagnosis but the expression of the personality disorder and hit it manifests itself. Persistent avoidant, antisocial, and passive-aggressive personality patterns can impair the ability for successful employment. Ideally, social integration and the components of supported employment should focus on job match between the client assessment and job analysis with continued psychological support.
Statement of Purpose

This study investigated the relationship between the four MCMI-III scales, which will include PTSD, avoidant, antisocial, and passive-aggressive personality patterns and the relationship to educational and vocational impairment status of Vietnam Veterans. Clinical Personality Patterns and the Clinical Syndrome of PTSD was measured by mean profile of Base Rate Scores of the MCMI-III along with vocational and educational impairment ratings obtained by an assessment committee. The implications for the predictive ability of the MCMI-III to assess personality subgroups with regard to educational and vocational status may refine the rehabilitation potential and disability ratings in these domains for Vietnam veterans.

Hypotheses

Based on the existing research on PTSD and the interactive effect of Axis II Personality Disorders on the effects of educational and vocational status, the following hypotheses were offered:

1) Elevated MCMI-III Profile Scores on the Clinical Personality Scales such as Avoidant, Antisocial, Passive-Aggressive, and Post Traumatic Stress Disorder will be predictive of an increase in educational impairment.
2) Elevated MCMI-III Profile Scores on the Clinical Personality Scales such as Avoidant, Antisocial, Passive-Aggressive, and Post Traumatic Stress Disorder will be predictive of an increase in vocational impairment.

3) A positive correlation will exist between educational, vocational and educational impairment ratings.
Method

Subjects

The subject pool was comprised of 40 male Vietnam veterans who received psychological services from an outpatient Readjustment Counseling Program. Subjects included in this study presented with a diagnosis of Post Traumatic Stress Disorder based on DSM-IV criteria as a consequence of combat related trauma. The mean age was 50 years with a range of 47 to 66 years old. The racial composition of the sample was 92.5 percent Caucasian, 5 percent African American, 2.5 percent American Indian. The mean educational level was 12.7 years and 65 percent were unemployed. The average number of months in combat was 12.6.

<table>
<thead>
<tr>
<th>Mean Age</th>
<th>50</th>
</tr>
</thead>
</table>
| Racial Composition | 92.5% Caucasian  
                        | 5.0% African-American  
                        | 2.5% American Indian |
| Mean Education Level | 12.7 years |

Materials

Employment status of subjects was determined from an occupational status data sheet which included employment history. Impairment was rated using demographic data from a self-report obtained from the clinical interview.
Clinical Personality Scale Scores were obtained from the Millon Clinical Multiaxial Inventory III.

Procedure

Two Multiple Regression Analyses were used to investigate the degree to which the independent variables of the MCMI-III Scales emerged in correlation with educational and vocational impairment. Further analyses of data investigated the correlation between educational and vocational impairment.

### Functional Impairment

Functional Impairment Ratings were obtained by a graduate committee who evaluated and came to consensual agreement regarding functional impairment across six domains measured by a Likert Scale with ratings on a continuum of 0 to 5, with the last measure being indicative of the most severe impairment. Additionally, Global Assessment of Functioning Ratings were also consensually agreed upon by the committee using the objective criteria established in DSM-IV to measure the veteran’s psychological, social, and occupational functioning. The GAF provides an overall rating of psychological functioning which measures psychological, social, and occupational functioning on a scale of 0-100.
Results

Correlations among the four MCMI-III scales are presented in Table 1. Results indicate that among the four scales, antisocial correlated positively with the avoidant and passive-aggressive scales. A significant positive correlation was found between antisocial and avoidant (.338, p < .05), and antisocial and passive-aggressive (.370, p < .05).

Table 1: Intercorrelations Among the Four Independent Variables

<table>
<thead>
<tr>
<th></th>
<th>ANT</th>
<th>AVO</th>
<th>PAS</th>
<th>PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Correlation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AN</td>
<td>1.000</td>
<td>.370*</td>
<td>.370*</td>
<td>.021</td>
</tr>
<tr>
<td>AVO</td>
<td>.338*</td>
<td>1.000</td>
<td>.269</td>
<td>.177</td>
</tr>
<tr>
<td>PAS</td>
<td>.370*</td>
<td>.269</td>
<td>1.000</td>
<td>-.034</td>
</tr>
<tr>
<td>PTSD</td>
<td>.021</td>
<td>.177</td>
<td>-.034</td>
<td>1.000</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AN</td>
<td>.033</td>
<td>.033</td>
<td>.019</td>
<td>.900</td>
</tr>
<tr>
<td>AVO</td>
<td>.019</td>
<td>.093</td>
<td>.093</td>
<td>.836</td>
</tr>
<tr>
<td>PAS</td>
<td>.900</td>
<td>.275</td>
<td>.836</td>
<td>.000</td>
</tr>
<tr>
<td>PTSD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>40</td>
<td>40</td>
<td>40</td>
<td>40</td>
</tr>
</tbody>
</table>

Two Multiple Regression Analyses for testing hypotheses 1 and 2 examined the predictive value of four independent variables, the MCMI-III scales, on two dependent measures, educational and vocational impairment. Table 2 and Table 3 illustrate the results of a Stepwise Regression Analysis indicating the amount of
variance attributed to each of the four predictors contributing to vocational and educational impairment, respectively.

Table 2: Stepwise Multiple Regression of MCMI-III Scales on Vocational Impairment

<table>
<thead>
<tr>
<th>Model</th>
<th>Variables</th>
<th>Entered</th>
<th>Removed</th>
<th>R</th>
<th>R Square</th>
<th>Adjusted R Square</th>
<th>Std. Error of the Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>PAS&lt;sup&gt;g&lt;/sup&gt;</td>
<td>.345</td>
<td>.119</td>
<td>.096</td>
<td>1.43</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>PTSD&lt;sup&gt;d&lt;/sup&gt;</td>
<td>.381</td>
<td>.145</td>
<td>.099</td>
<td>1.43</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>AVO&lt;sup&gt;e&lt;/sup&gt;</td>
<td>.419</td>
<td>.176</td>
<td>.107</td>
<td>1.42</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>ANT&lt;sup&gt;f&lt;/sup&gt;</td>
<td>.448</td>
<td>.201</td>
<td>.110</td>
<td>1.42</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>ANT&lt;sup&gt;f&lt;/sup&gt;</td>
<td>.448</td>
<td>.201</td>
<td>.110</td>
<td>1.42</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. Dependent Variable: VI
c. Independent Variables: (Constant), PAS
d. Independent Variables: (Constant), PAS, PTSD
e. Independent Variables: (Constant), PAS, PTSD, AVO
f. Independent Variables: (Constant), PAS, PTSD, AVO, ANT

The coefficients presented in Table 4 demonstrate that the Passive-Aggressive Scale and the Avoidant Scale were related to vocational impairment in the sample. The data revealed the Passive-Aggressive Scale contributed to most of the variance at 11.9 percent. As illustrated in Table 3, only 1 percent of the variance could be accounted for by the independent variables as predictors of educational impairment.
Table 3: Stepwise Multiple Regression of MCMI-III Scales in Educational Impairment

<table>
<thead>
<tr>
<th>Model</th>
<th>Variables</th>
<th>Entered</th>
<th>Removed</th>
<th>R</th>
<th>R Square</th>
<th>Adjusted R Square</th>
<th>Std. Error of Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>PAS&lt;sup&gt;c&lt;/sup&gt;</td>
<td>.152</td>
<td>.023</td>
<td>-.003</td>
<td>1.27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>PTSD&lt;sup&gt;d&lt;/sup&gt;</td>
<td>.209</td>
<td>.044</td>
<td>-.008</td>
<td>1.27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>AVO&lt;sup&gt;e&lt;/sup&gt;</td>
<td>.237</td>
<td>.056</td>
<td>-.023</td>
<td>1.28</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>ANT&lt;sup&gt;f&lt;/sup&gt;</td>
<td>.259</td>
<td>.067</td>
<td>-.039</td>
<td>1.29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>ANT&lt;sup&gt;f&lt;/sup&gt;</td>
<td>.259</td>
<td>.067</td>
<td>-.039</td>
<td>1.29</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. Dependent Variable: EI
c. Independent Variables: (Constant), PAS
d. Independent Variables: (Constant), PAS, PTSD
e. Independent Variables: (Constant), PAS, PTSD, AVO
f. Independent Variables: (Constant), PAS, PTSD, AVO, ANT

Overall, the results in Table 2 indicate that 20.1 percent of the variance could be attributed to the four personality scales as predictors of vocational impairment. Comparatively, the analysis revealed the Passive-Aggressive Scale contributed to most of the variance at 11.9 percent. As illustrated in Table 3, only 6.7 percent of the variance could be accounted for by the independent variables as predictors of educational impairment.

The coefficients presented in Table 4 demonstrate that the Passive-Aggressive Scale and the Avoidant Scale were related to vocational impairment in
an unexpected direction, while the PTSD and Antisocial Personality Scales were related in the expected, positive direction. Considered separately, only the passive-aggressive scale was significantly predictive of impairment.

Table 4: Standard Coefficients Between the MCMI-III Scales and Vocational Impairment

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td>Beta</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>(Constant)</td>
<td>7.261</td>
<td>1.675</td>
<td>-0.345</td>
</tr>
<tr>
<td></td>
<td>PAS</td>
<td>-4.5E-02</td>
<td>0.020</td>
<td>-0.2266</td>
</tr>
<tr>
<td>2</td>
<td>(Constant)</td>
<td>5.599</td>
<td>2.285</td>
<td>-0.339</td>
</tr>
<tr>
<td></td>
<td>PAS</td>
<td>-4.5E-02</td>
<td>0.020</td>
<td>-0.2232</td>
</tr>
<tr>
<td></td>
<td>PTSD</td>
<td>1.8E-02</td>
<td>0.017</td>
<td>0.162</td>
</tr>
<tr>
<td>3</td>
<td>(Constant)</td>
<td>5.959</td>
<td>2.296</td>
<td>-0.289</td>
</tr>
<tr>
<td></td>
<td>PAS</td>
<td>-3.8E-02</td>
<td>0.021</td>
<td>-0.184</td>
</tr>
<tr>
<td></td>
<td>PTSD</td>
<td>2.2E-02</td>
<td>0.017</td>
<td>0.197</td>
</tr>
<tr>
<td></td>
<td>AVO</td>
<td>-1.6E-02</td>
<td>0.014</td>
<td>-0.184</td>
</tr>
<tr>
<td>4</td>
<td>(Constant)</td>
<td>5.479</td>
<td>2.337</td>
<td>-0.342</td>
</tr>
<tr>
<td></td>
<td>PAS</td>
<td>-4.5E-02</td>
<td>0.022</td>
<td>-0.2068</td>
</tr>
<tr>
<td></td>
<td>PTSD</td>
<td>2.3E-02</td>
<td>0.017</td>
<td>0.199</td>
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a. Dependent Variable: VI
A Pearson Product Moment Correlation Coefficient was computed to measure the degree of relationship between educational and vocational impairment. Results indicated there was a significant correlation of .720.
Table 5: Pearson Product Moment Correlation Coefficient Between Educational and Vocational Impairment

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**.Correlation is significant at the 0.01 level (2-tailed).

Table 6: Average Mean Scores and Standard Deviations for the Four MCMI-III Scales

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<td>.367*</td>
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<table>
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N

- MI: 40
- EI: 40
- FI: 40
- PI: 40
- VI: 40
- SI: 40

**Correlation is significant at the 0.01 level (2-tailed).
*Correlation is significant at the 0.05 level (2-tailed).

Correlations among the six impairments are presented in Table 7. Two Stepwise Multiple Regression Analyses examined the amount of variance contributed by the Impairment Scales to Vocational and Educational Impairment. Table 8 indicates 68.3 percent of the variance could be attributed to impairment scales as a predictor of vocational impairment. Comparatively, the analysis revealed in Table 9 that 73.3 percent of the variance was accounted for by the independent variables as predictors of educational impairment.
Table 8: Stepwise Multiple Regression of Impairment with Vocational

Model Summary

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a. Dependent Variable: VI
c. Independent Variables: (Constant), SI
d. Independent Variables: (Constant), SI, PI
e. Independent Variables: (Constant), SI, PI, FI
f. Independent Variables: (Constant), SI, PI, FI, EI
g. Independent Variables: (Constant), SI, PI, FI, EI, MI

d. Independent Variables: (Constant), SI

Table 9: Stepwise Multiple Regression of Impairments with Educational

Model Summary

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a. Dependent Variable: EI
c. Independent Variables: (Constant), SI
d. Independent Variables: (Constant), SI, PI
e. Independent Variables: (Constant), SI, PI, MI
f. Independent Variables: (Constant), SI, PI, MI, FI
Discussion

The present study investigated the amount of variance which specific personality scales on the Millon contributed to vocational and educational impairment. Although the sample size (N=40) in this study prevents any definitive conclusions, the results do support that taken as a whole, the four scales contributed to a significant amount of the variance as predictors of vocational impairment, but minimally to educational impairment.

The purpose of this discussion is to explain contrary to what would be expected, the passive-aggressive and avoidant scales were related to vocational impairment in an unexpected direction. Veterans diagnosed with the representative features inherent in a passive-aggressive personality and avoidant profile would be characterized by a pervasive pattern of passive resistance and inimical behaviors in social and occupational performance. Additionally, the avoidant style would appear interpersonally to range from aversive to withdrawn. Although the research suggests that there is no direct correlation between an individual’s diagnosis and functional skills, there is evidence to support that how well and individual can adapt socially with others is a predictor of future work performance. It is more likely that passive-aggressive and avoidant styles are less likely to be vocationally disruptive relative to antisocial diagnostic patterns in certain contexts.
Prior investigators have confirmed that although the passive-aggressive scale on the MCMI-III appears to be positively correlated to personality disorders in general, there is minimal correlation between this scale and the DSM-IV category of passive-aggressive personality. Thus, Millon's characterization of the passive-aggressive pattern may be less dysfunctional than the full criteria required for the DSM-IV diagnosis. Comparatively to the effects of other personality disorders, a passive-aggressive style in occupational performance may constitute a less pronounced maladaptive style in the vocational domain. An antisocial personality pattern, which is characterized active interpersonal style ranging from contentious to antagonistic behavior, is more likely to lead to confrontations with authority figures than a passive aggressive pattern characterized by ambivalence.

When considering vocational impairment, one of the factors often neglected is the interactive effect between personality variables, organizational climate, and culture. The compatibility between an individual and situational demands in the workplace may be enhanced by the proper fit between an individual and his environment. An individual who is assessed as being passive-aggressive may adapt quite well in an organizational climate where there are minimal demands for group cohesion and team projects.

Further implications of this study are the interactive effects in treatment between personality disorders and PTSD. Although prior studies have shown an
emerging profile pattern characteristic of combat veterans on major personality assessment measures such as the MMPI-II, the MCMI-III provides more specific information related to DSM-IV diagnostic categories, specifically in the area of personality disorders. Parallel to the increasing interest in the interactive effect of coexisting Axis I and Axis II disorders on treatment outcome, this study suggests information provided by the MCMI-III personality scales does give the clinician the additional information regarding the contribution of Axis II personality disorders to impairment in the Vietnam veteran suffering from PTSD. Although the personality disorders share common variance with criteria and symptoms of PTSD, what is clinically relevant is that the traumatic event can effect normal personality patterns and transform them in pathological directions depending on the nature of the ego development at which the trauma occurs (Hyer, 1992).

At a time when the mental health service delivery systems are strained, treatment models which reduces the utilization of repeated hospitalizations may reduce overall mental care costs. Funari (1991) suggests that the identification of Post Traumatic Stress Disorder subtypes is important in that it may lead to more specialized treatment modalities to reduce dropout rates and decrease frequent hospitalizations. For mental health practitioners utilizing a conceptual model inclusive of the interactive effect between Axis I and Axis II disorders, treatment may be tailored to individual differences.
A major limitation of this study was due to the small sample size, the results may not generalize to other populations with different demographics. Since the study was limited to a population of veterans who were self-referred for outpatient treatment, future research may want to compare these results with those of well adjusted, non-treatment seeking veterans with stable employment histories. Further limitations of the study are the overlap of some of the selected scales and the lack of correspondence between the passive-aggressive scale DSM-IV criteria. Previous data suggest that differentiation of personality disorders from Axis I, from other personality disorders, and from normal personality functioning is not always apparent (Widiger and Axelrod, 1995). In addition, further research may benefit from a comprehensive investigation of the scales, specifically the Self Defeating Personality Style characterized by a lower adjustment potential and greater psychopathology.

According to Lewin (1936), "Every scientific psychology must take into account whole situations, i.e., the state of both person and environment." Overall, the utility of identifying the MCMI-III in predicting functional impairment across all domains requires the clinician to consider contextual factors and the interactive effects of human social systems in addition to the data a self-report inventory can provide.
References


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|x 2.06 | x 2.06 | x 2.06 |
Table A:
MILLON CLINICAL MULTIAXIAL INVENTORY - III
PROFILE OF COMBAT VICTIMS (N=40)

VALID PROFILE

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Instructions: Rate the degree to which the client is capable of functioning in the following six areas.

1. **Personal Impairment:**
   - Unable to manage activities of daily living (ADLs) such as hygiene, meals, and personal care.
   - **Rating Scale:** 0 = None, 1 = Mild, 2 = Moderate, 3 = Considerable

2. **Cognitive Impairment:**
   - Inability to pay attention, concentrate, memory and task completion.
   - **Rating Scale:** 0 = None, 1 = Mild, 2 = Moderate, 3 = Considerable

3. **Vocational Impairment:**
   - Inability to obtain and maintain employment; consider number of jobs and underemployment.
   - **Rating Scale:** 0 = None, 1 = Mild, 2 = Moderate, 3 = Considerable

4. **Marital Impairment:**
   - Inability to form and maintain healthy, committed relationships, consider adjusting scale for primary relationship.
   - **Rating Scale:** 0 = None, 1 = Mild, 2 = Moderate, 3 = Considerable

5. **Social Impairment:**
   - Inability to form and maintain healthy interpersonal relationships.
   - **Rating Scale:** 0 = None, 1 = Mild, 2 = Moderate, 3 = Considerable

6. **Overall Impairment Rating:**
   - **Rating Scale:** 0 = None, 1 = Mild, 2 = Moderate, 3 = Considerable

Notes:
- 0 = None
- 1 = Mild
- 2 = Moderate
- 3 = Considerable

- 4 = Severe
- 5 = Considerable
### Table B

**Functional Impairment Assessment**

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<td><strong>(2) Educational Impairment:</strong> 0 1 2 3 4 5 Inability to pay attention, concentrate, memory and task completion.</td>
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<td><strong>(3) Vocational Impairment:</strong> 0 1 2 3 4 5 Inability to obtain and retain employment; consider number of jobs and underemployment.</td>
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<tr>
<td></td>
<td><strong>(4) Marital Impairment:</strong> 0 1 2 3 4 5 Inability to form and maintain a healthy, committed relationship; consider number of relationships (marital or primary).</td>
</tr>
<tr>
<td></td>
<td><strong>(5) Familial Impairment:</strong> 0 1 2 3 4 5 Inability to maintain a healthy family relationship.</td>
</tr>
<tr>
<td></td>
<td><strong>(6) Social Impairment:</strong> 0 1 2 3 4 5 Inability to form and maintain healthy interpersonal relationships.</td>
</tr>
<tr>
<td></td>
<td><strong>Overall Impairment Rating:</strong> 0 1 2 3 4 5</td>
</tr>
<tr>
<td></td>
<td><strong>Ratings:</strong> 0 = None 1 = Mild 2 = Definite 3 = Considerable 4 = Severe 5 = Catastrophic</td>
</tr>
</tbody>
</table>
APPENDIX C

Evaluation Materials Enclosed ( )

1) Counseling Intake Assessment
2) Readjustment Counseling Report and Treatment Plan
3) Assessment of Vietnam Combat-Related Stress
4) Diagnostic Criteria: 309.89

Richard T. Elmoe, Jr, Ph.D.
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Melbourne, FL 32901
Intake Evaluation
Readjustment Counseling Services

Veteran's Name/ID #: __________________________

1. REFE R R A L / I D E NT I F Y I N G I N F O R M A T I O N

Conference One: Date: _________________________
Conference Two: Date: _________________________
Conference Three: Date: _________________________

Evaluation Materials Enclosed ( ):
1) Counseling Intake Assessment
2) Readjustment Counseling Report and Treatment Plan
3) Assessment of Vietnam Combat-Related Stress
4) Diagnostic Criteria: 309.89
5) Eligibility Criteria
6) Treatment Recommendations
7) MCMI-III Profile

Provider

Richard T. Elmore, Jr., Ph.D., P.A.
2210 S. Front Street - Suite 307
Melbourne, FL 32901
COUNSELING INTAKE ASSESSMENT

Veteran's Name/ID #: __________________________________________

Dates of Intake/Evaluation: 1. _________ 2. _________ 3. _________

1. REFERRAL/IDENTIFYING INFORMATION

Age: _________ Racial/Ethnic Background: ________________________

Served in: □ Vietnam □ Lebanon □ Grenada
□ Panama □ Persian Gulf

Served in other areas of campaign? Specify: ________________________

Source of Referral to Contractor: _________________________________

2. PRESENTING PROBLEMS

Marked Trauma:

Severity of Presenting Problems (i.e., to what extent do these problems disrupt the veteran's social and occupational functioning?); 

Persistently Re-experienced:

Persistent Avoidance or Numbing:
Persistent Arousal:

Other:

History and Duration of Presenting Problems (i.e., how long have these problems been occurring?):

Severity of Presenting Problems (i.e., to what extent do these problems disrupt the veteran’s social and occupational functioning?):

3. **PRESENT SOCIAL/FAMILY CONTEXT**

Marital Status: _______________    Number of Children: ___________

Residential Status: (Does veteran reside alone or with others?):

Occupation/Type of Employment:
Lifestyle/Support Systems/Leisure and Recreational Activities:

4. PSYCHOLOGICAL/MEDICAL HISTORY

Serious medical conditions/illnesses in the past, if any (including wounds or injuries sustained in combat or while on active duty):

Current medical problems, if any (indicate whether veteran is currently undergoing treatment for any significant medical problems):

Substance Abuse Problems, current and past:

Briefly summarize any past mental health treatment (both inpatient and outpatient):

If veteran is currently receiving mental health services at a facility other than your facility, indicate service provider and focus of treatment:
5. **PRE-MILITARY HISTORY**
Family of origin, school involvement, substance abuse, acting out/legal problems, trauma (death in family, incest, abuse, disasters):

6. **MILITARY HISTORY**
Pre/during/post - Vietnam/Lebanon/Grenada/Panama/Persian Gulf adjustment, draft/volunteer, disciplinary actions, duties, injuries, disabilities, trauma, homecoming experiences:

**Pre-War Zone:**

**War Zone:**
Post-War Zone:

Specific nature of MOS/duties in War Zone:

7. **POST-MILITARY HISTORY**
Social/interpersonal functioning, schools, jobs, marriages, children, locations, legal problems, substance abuse, etc.:

8. **OBSERVATIONS/CRITICAL ISSUES**
Assessment of suicidal/homicidal ideation, history of and need for intervention:
9. ASSESSMENT

Assessment of veteran and presenting problem(s). Discussion of the veteran’s strengths, assets, motivation, support systems and counselor’s impression and conceptualization of the veteran:

A. Presenting Problems and Symptoms:

Impressions:

DSM-IV

Axis I

Axis II

Relationship of presenting problems to military history:

10. INITIAL TREATMENT PLAN

Type of counseling recommended and proposed focus of counseling:

Client’s counseling goals (i.e., what does the client wish to accomplish and what types of changes are being sought with regard to presenting problems, etc?):

1.

2.

3.

Has treatment plan been discussed with the Veteran?  [ ] Yes  [ ] No

Provider 

Date

Richard T. Elmore, Jr., Ph.D., P.A.

2210 S. Front Street - Suite 307

Melbourne, FL 32901
READJUSTMENT COUNSELING PROGRESS REPORT AND TREATMENT PLAN

Veteran’s Name/ID #: ____________________________

A. Presenting Problems and Symptoms:
   (The person has been exposed to a traumatic event in which both of the following were present:
   1. the person experienced or witnessed a situation involving death or serious injury, or
   2. the person was threatened with) death or serious injury, or
   3. the person observed death or serious injury, or
   4. the person was exposed to (theme of event) during the event, or

B. Relationship of Presenting Problems to Military Experiences:

C. Total Number of Individual Counseling Visits Since Initial Intake: ___
   Total Number of Group Counseling Visits Since Initial Intake: ___

D. Summarize progress made by client thus far with regards to Presenting Problems, Counseling Goals and Treatment Plan:
   1. Completed intake evaluation.
   2. Began therapeutic relationship.
   3. Set initial goals.

E. Client’s Current Counseling Goals (If different from those previously reported):
   Same as reported in intake.

F. Current Treatment Plan (i.e., type of counseling recommended and proposed focus of counseling):
   1. ____________________________________________________________
   2. ____________________________________________________________
   3. ____________________________________________________________

G. Has treatment plan been discussed with the Veteran? □ Yes □ No

________________________________________________________________________

Provider __________________________ Date __________________________

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Melbourne, FL 32901
Readjustment Counseling Services

Veteran's Name/ID #: ____________________________

Diagnostic Criteria: 309.81 Post-traumatic Stress Disorder (DSM IV)

A. The person has been exposed to a traumatic event in which both of the following were present:
   1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others and
   2) the person’s response involved intense fear, helplessness, or horror.

   Event: Combat Exposure

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
   □ 1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
   □ 2) recurrent distressing dreams of the event.
   □ 3) acting or feeling as if the traumatic event were recurring (includes a sense or reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).
   □ 4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
   □ 1) efforts to avoid thought, feelings, or conversations associated with the trauma.
   □ 2) efforts to avoid activities, places, or people that arouse recollections of the trauma.
   □ 3) inability to recall an important aspect of the trauma.
   □ 4) markedly diminished interest or participation in significant activities.
   □ 5) feeling of detachment or estranged from others.
   □ 6) restricted range of affect.
   □ 7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).
D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

- difficulty falling or staying asleep.
- irritability or outbursts of anger.
- difficulty concentrating.
- hypervigilance.
- exaggerated startle response.

E. Duration of the disturbance is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- Acute: if duration of symptoms is less than three months.
- Chronic: if duration of symptoms is three months or more.
- With Delayed Onset: if onset is at least six months after the stressor.

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ELIGIBILITY CRITERIA
Readjustment Counseling Services

Veteran’s Name/ID #: ____________________________

Significant issues which comprise the Veteran’s Post-Vietnam War readjustment problems are one or more of the following:

☐ 1) Psycho-social problems related to exposure to war trauma.

☐ 2) Psycho-social problems related to other aspects of duty in the Southeast Asia Combat Zone.

☐ 3) One or more of the psychological symptoms included in the DSM-IV diagnosis and associated features of Post Traumatic Stress Disorder. Also, cases where unusual stressors occurred during the military duty period but where an underlying stress disorder is not manifested per the DSM-IV criteria, although it affects other aspects of the veteran’s life.

☐ 4) Psycho-social problems derived from stressors unique to military duty during the Vietnam Era, whether the individual served in or outside the combat zone.

☐ 5) Psycho-social problems related to type of military discharge.

☐ 6) Psycho-social problems related to substance abuse connected with military duty or post-military readjustment.

☐ 7) Psycho-social problems related to Post-Vietnam War homecoming experiences.

☐ 8) Psychological concern over possible Agent Orange exposure and ramifications.

☐ 9) Generalized alienation from society manifested by interruption of normal readjustment processes in connection with the Vietnam experience.

Provider: Richard T. Elmore, Jr., Ph.D., P.A.
Date:

2210 S. Front Street - Suite 307
Melbourne, FL 32901
TREATMENT RECOMMENDATIONS
Readjustment Counseling Services

Veteran's Name/ID #: ________________________________

Services which are recommended as part of the treatment plan are one or more of the following:

☐ 1) Individual Counseling
☐ 2) Marriage Counseling
☐ 3) Family Counseling
☐ 4) Group Counseling
   4.1 - “Debriefing Group”
   4.2 - Stress Management Group
   4.3 - Couple’s Communication Group
   4.4 - Effective Parenting
   4.5 - Vocational/Employment Counseling
☐ 5) Substance Abuse Counseling
☐ 6) Employment (job and career) Counseling
☐ 7) Benefits Counseling
☐ 8) Social Services Counseling and Referral
☐ 9) Family Support Services
   9.1 - Spouse Support Group
   9.2 - Parent Support Group
   9.3 - Child Support Group
☐ 10) Other: PTSD Treatment Program

____________________________________  __________________________
Provider                                       Date

Richard T. Elmore, Jr., Ph.D., P.A.
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Melbourne, FL 32901
DIAGNOSTIC CRITERIA FOR POSTTRAUMATIC STRESS DISORDER

A. The person has been exposed to a traumatic event in which both of the following were present:
   1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
   2) the person's response involved intense fear, helplessness, or horror.

B. The traumatic event is persistently reexperienced in one or more of the following ways:
   1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions
   2) recurrent distressing dreams of the event
   3) acting or feeling as if the traumatic event were recurring
   4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
   5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness as indicated by three or more of the following:
   1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
   2) efforts to avoid activities, places, or people that arouse recollections of the trauma
   3) inability to recall a certain aspect of the trauma
   4) markedly diminished interest in significant activities
   5) feeling of detachment or estrangement from others
   6) restricted range of affect
   7) sense of foreshortened future

D. Persistent symptoms of increased arousal as indicated by two of the following:
   1) difficulty falling or staying asleep
   2) irritability or outbursts of anger
   3) difficulty in concentrating
   4) hypervigilance
   5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, or D) is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
RESEARCH CRITERIA FOR PASSIVE-AGGRESSIVE PERSONALITY DISORDER

A. A pervasive pattern of negativistic attitudes and passive resistance to the demands for adequate performance, beginning in early adulthood and present in a variety of contexts as indicated by four of the following:
   1) passively resists fulfilling routine social and occupational tasks
   2) complains of being misunderstood and unappreciated by others
   3) is sullen and argumentative
   4) unreasonably criticizes and scorns authority
   5) expresses envy and resentment toward those apparently more fortunate
   6) voices exaggerated and persistent complaints of personal misfortune
   7) alternates between hostile defiance and contrition

B. Does not occur exclusively during Major Depressive Episodes and is not better accounted for by Dysthymic Disorder.

DIAGNOSTIC CRITERIA FOR 301.7 ANTISOCIAL PERSONALITY DISORDER

A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three or more of the following:
   1) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest.
   2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.
   3) impulsivity or failure to plan ahead
   4) irritability and aggressiveness, as indicated by repeated physical fights or assaults
   5) reckless disregard for safety of self or others
   6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
   7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

B. The individual is at least 18 years of age.

C. There is evidence of Conduct Disorder with onset before age 15.

D. The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.
DIAGNOSTIC CRITERIA FOR 301.82 AVOIDANT PERSONALITY DISORDER

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation beginning by early adulthood and present in a variety of contexts, as indicated by four or more of the following:

1) avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection

2) is unwilling to get involved with people unless certain of being liked

3) shows restraint within intimate relationships because of the fear of being shamed or ridiculed

4) is preoccupied with being criticized or rejected in social situations

5) is inhibited in new interpersonal situations because of feelings of inadequacy

6) views self as socially inept, personally unappealing or inferior to others.

7) is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing