FULL-LENGTH ARTICLE

The MCMI-III in Child Custody Evaluations: A Normative Study

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ABSTRACT. This study provides normative data on the Millon Clinical Multiaxial Inventory-III (MCMI-III) among 259 child custody examinees who were obtained from private practice settings in four different states. The mean MCMI-III profile in this sample was an elevation on

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Scale Y (Desirability), with subclinical elevations on Scales 4 (Histrionic), 5 (Narcissistic), and 7 (Compulsive). Females scored significantly higher than males on Scales 4, 5, and 7. Moreover, mean Base Rate (BR) scores were very low for most scales. With the exception of Scales 4 and 7 for females, the frequency of clinically significant elevations (i.e., BR $\geq$ 75) on MCMI-III scales was very low among child custody litigants. Results from this study provide empirical support for the position that the MCMI-III does not overpathologize child custody examinees. Some interpretive guidelines are offered to reduce the likelihood of false positive diagnoses on those few scales where such errors may arise. This study provides support for continued use of the MCMI-III in child custody evaluations.

KEYWORDS. MCMI-III, child custody, forensic assessment, norms

Over the past few decades, psychologists have become more involved in the legal process by providing consultation to courts on a variety of matters. One area that has been particularly adversarial is the use of expert psychological testimony in cases involving disputes over child custody and visitation. As a result of this growing area of psychological expertise in court, there has been increased attention given to the use of psychological tests in child custody proceedings.

The traditional approach to conducting child custody evaluations has been a comprehensive one in which specific issues and questions are posed to the examiner and multiple sets of data are integrated to answer these questions (Halon, 1990). Typically, comprehensive psychological evaluations are conducted on each parent, the individual children, and potential step-parents and detailed observations are made of parent-child interactions. Although there once was very little direction available for child custody examiners, recently a number of professional standards have been developed to guide forensic mental health practice and several texts on child custody evaluations have appeared in the literature. For instance, the American Psychological Association (1994) has drafted guidelines for conducting child custody evaluations, as have several states, including Georgia (Georgia Psychological Association, 1990), Nebraska (Nebraska Psychological Association, 1986), New Jersey (New Jersey Board of Psychological Examiners, 1993), and Oklahoma (Oklahoma Psychological Associa-

tion, 1988). Comprehensive guides to conducting child custody evaluations include books by Ackerman (1995) and Gould (1998).

When traditional psychological tests are applied in forensic contexts, it is the duty of the expert to not only use methods that are reliable and valid, but also ones that have relevance to the ultimate legal issue being litigated (Heilbrun, 1992). With respect to child custody evaluations, traditional psychological tests are relevant if they provide clinical data that will help guide determinations as to what is in the best interests of the children, since this is the common legal test for determining child custody (Melton, Petrila, Poythress, & Slobogin, 1997).

Prior research on the testing practices of psychologists who conduct child custody evaluations reveal that the most commonly used tests with adults are the Minnesota Multiphasic Personality Inventory (MMPI), Rorschach Inkblot Method, and Wechsler Adult Intelligence Scale-Revised (WAIS-R). Keilin and Bloom (1986) found that the MMPI was used by about 71% of child custody evaluators who were surveyed and Ackerman and Ackerman (1997) found that the MMPI-2 was used by about 92% in a later study of child custody evaluators. Despite widespread use of the MMPI-2, there was little information on how child custody litigants actually performed on the MMPI-2 until Bathurst, Gottfried, and Gottfried (1997) conducted their large study.

Over the last fifteen years, the Millon Clinical Multiaxial Inventory (MCMI; Millon, 1983, 1987, 1994; Millon, Davis, & Millon, 1997) has become a more established psychological assessment instrument. Although Keilin and Bloom (1986) did not cite the MCMI as a frequently used instrument in child custody evaluations, a more current study by Ackerman and Ackerman (1997) found that about 34% of child custody evaluators utilized the MCMI with adults. This finding reflects a general trend that has found the MCMI to be frequently used in forensic psychological evaluations (Borum & Grisso, 1995; McCann & Dyer, 1996).

Use of the Millon Clinical Multiaxial Inventory-III (MCMI-III; Millon, 1994; Millon, Davis, & Millon, 1997) in child custody proceedings has been controversial. Some have argued that the clinical nature of the instrument renders it inappropriate for use in child custody evaluations, which have been conceptualized by some as nonclinical types of examinations (Ackerman, 1995; Ackerman & Ackerman, 1997). Moreover, because norms for the MCMI-III were developed in clinical settings, they have been viewed by some as inappropriate in

child custody cases because they supposedly lead to the MCMI-III narrative report producing interpretations that overpathologize individuals being evaluated in child custody disputes (Otto & Butcher, 1995). A significant issue that appears to underlie these concerns is whether the MCMI-III is diagnostically accurate in child custody settings.

However, there are several reasons to view child custody evaluations as clinical in nature, such as the highly conflicted and contentious nature of marital dissolution and the need to consider the possible presence of psychopathology and its potential impact on parenting. In addition, the MCMI-III was designed for use with ''individuals who evidence problematic emotional and interpersonal symptoms *or* who are undergoing professional psychotherapy *or* a psychodiagnostic evaluation'' (Millon, Davis, & Millon, 1997, p. 6, emphasis added). Child custody disputes certainly fit in the realm of ''individuals who . . . are undergoing . . . a psychodiagnostic evaluation'' and the revised MCM-III manual has also endorsed use of the instrument in child custody evaluations (Millon, Davis, & Millon, 1997).

Despite the fact that McCann and Dyer (1996) recommended clinicians use the MCMI-II instead of the MCMI-III in forensic settings because of scant validity data in the original edition of the MCMI-III manual (Millon, 1994), there have been recent advances in the literature which outdate this recommendation and which now support validity of the MCMI-III and its use in forensic evaluations (Craig, R. J., 1999; Craig & Bivens, 1998; Craig, Bivens, & Olson, 1997; Davis & Hays, 1997; Davis, Wenger, & Guzman, 1997; Dyce, O'Connor, Parkins, & Janzen, 1997; Dyer, 1997; Dyer & McCann, 2000). Moreover, the MCMI-III manual has been revised and the most recent edition includes a more expanded and detailed validity study which supports use of the MCMI-III in forensic assessments (Millon, Davis, & Millon, 1997).

Recently, Rogers, Salekin, and Sewell (1999) criticized forensic use of the Millon inventories by asserting that neither the MCMI-II nor the MCMI-III were validated against DSM-IV or legal criteria and that the instruments supposedly have poor convergent and discriminant validity. However, Dyer and McCann (2000) cited several methodological shortcomings of the Rogers et al. (1999) study, including arbitrary reversal of predictor and criterion, an incomplete review of the literature that failed to consider the most current edition of the MCMI-III manual, inaccurate statements about content validity of the MCMI-III,

misleading criticisms about use of the MCMI-III for evaluating legally relevant issues, and serious errors in the multitrait-multimethod procedures employed by Rogers et al. (1999) that render their findings meaningless. Therefore, while forensic application of the Millon inventories in forensic settings is a topic of debate, there remains substantial support for continued use of the MCMI-III in many types of forensic evaluations (Dyer, 1997; Dyer & McCann, 2000)

This paper reports findings from a normative study of how child custody litigants perform on the MCMI-III. We sought to answer three general questions in this study: (1) How do individuals undergoing a child custody evaluation typically score on the MCMI-III; (2) Does the MCMI-III overpathologize child custody examinees; and (3) Are there any modifications in interpretation of the MCMI-III that may be required in child custody settings?

METHOD

Subjects

The subjects for this study were 259 individuals who completed the MCMI-III as part of a child custody evaluation that was being adjudicated. Subjects were obtained from six private practice settings in which forensic mental health services, including child custody evaluations, were conducted and in which the MCMI-III is routinely administered. The sample was obtained from four different states, namely Florida, New York, California, and Kentucky. There were 127 males and 130 females in the sample, with two subjects whose gender, while available for scoring the MCMI-III protocol, was not available when data were compiled for this study. Table 1 provides information on the demographic characteristics for males, females, and the total sample on such variables as age, education, marital status, number of children at issue, and race. Overall, the data in Table 1 indicate that the child custody examinees in this study tended to be white, in their late thirties, college educated, and separated at the time of the evaluation. There were no prominent differences noted between males and females on demographic characteristics. Nearly all of the MCMI-III protocols were obtained in cases where both parents were being examined. In a very few cases, only one parent was examined. Thus, a

TABLE 1. Demographic Characteristics of Sample

Variable	Males (n = 127)	Females (n = 130)	Total Sample (n = 259)
Age			
Mean	39.13	36.15	37.62
Standard Deviation	8.55	7.46	8.15
Education			
High School	45	53	94
College	45	41	86
Graduate School	17	13	30
No Data Available	24	23	49
Marital Status			
Single	7	7	14
Married	5	9	14
Remarried	9	10	19
Divorced	19	18	37
Separated	34	34	68
No Data Available	53	52	107
Children at Issue			
Mean	1.82	1.92	1.84
Standard Deviation	0.83	0.86	0.85
Race			
White	79	80	159
African-American	1	0	1
Hispanic	8	3	11
Other	3	0	3
No Data Available	39	44	85

majority of cases in this study reflect a standard child custody evaluation in which both parents are evaluated.

Procedure

The MCMI-III protocols were collected from each private practice setting along with case relevant information, such as demographic characteristics of each individual, any custody or visitation decision that had been rendered by the court, and any reports of domestic violence. The demographic characteristics in Table 1 are presented in terms of raw data, rather than percentages, because of missing data for several subjects. Computation of percentages based on either the total

sample or the number of subjects for whom data were available might be misleading. Data were missing for large portions of the sample because certain demographic data were not available for some of the private practice settings. All MCMI-III protocols had been computer scored and were valid in that the Validity Index had a raw score of zero and Scale X raw scores were within the acceptable range as defined in the test manual (Millon, Davis, & Millon, 1997). The demographic information and BR scores from the MCMI-III scales were entered into a computerized data base for analysis.

RESULTS

The mean MCMI-III profiles for males, females, and the combined sample are provided in Table 2. For the entire sample, the mean MCMI-III profile was characterized by a clinically significant elevation (i.e., BR $\geq$ 75) on Scale Y (Desirability); all other mean scale elevations were below this clinically significant level. However, the mean profile for the total sample masks a statistically significant difference that existed between males and females. For males, the mean MCMI-III profile closely matched the mean profile for the total sample, with a clinically significant elevation on Scale Y, but there were no other significant elevations. For females, the mean MCMI-III profile consisted of clinically significant elevations on Scales Y and 4 (Histrionic), and an elevation on Scale 7 (Compulsive) that approached clinical significance.

Given these observed differences between male and female profiles, statistical comparisons were made between MCMI-III scale means for each of these two groups using *t*-tests for independent groups. Because 27 scale comparisons were made, there was a risk of making Type I errors in that at least one comparison could be expected to be significant by chance alone. The required level of statistical significance was therefore adjusted downward in order for a comparison to be considered significant by dividing the standard ($p < .05$) level by the number of statistical tests conducted (i.e., 27). This resulted in adoption of a more conservative level ($p < .001$) that was required for statistical significance. Table 2 reports the *t* values for each comparison between male and female MCMI-III scale means. On scales 4, 5, and 7, females scored significantly higher than males. It is important to note that although these differences were statistically

TABLE 2. Mean MCMI-III BR Scores of Child Custody Evaluation Examinees

Scale	Males (n = 127)		Females (n = 130)		Total Sample (n = 259)		
	Mean	S.D.	Mean	S.D.	Mean	S.D.	t
X. Disclosure	30.45	15.50	32.73	16.64	31.64	16.10	−1.14
Y. Desirability	75.83	13.50	75.64	11.73	75.56	13.06	0.12
Z. Debasement	20.39	19.28	25.70	23.78	23.10	21.87	−1.97
1. Schizoid	22.69	19.82	23.84	21.31	23.15	20.56	−0.45
2A. Avoidant	19.07	19.65	23.26	21.18	21.05	20.53	−1.64
2B. Depressive	20.89	22.81	17.82	17.18	19.25	20.16	1.22
3. Dependent	33.14	22.53	33.10	24.69	33.09	23.60	0.01
4. Histrionic	61.87	14.79	77.29	17.89	69.75	18.16	−7.54***
5. Narcissistic	62.40	12.45	67.86	13.45	65.22	13.28	−3.38***
6A. Antisocial	31.53	19.48	29.34	19.92	30.34	19.73	0.89
6B. Sadistic	27.48	22.79	29.30	24.17	28.44	23.56	−0.62
7. Compulsive	63.61	12.91	72.97	18.88	68.37	15.70	−5.00***
8A. Negativistic	16.78	16.19	18.64	18.66	17.73	17.48	−0.85
8B. Self-Defeating	14.62	19.44	19.52	22.75	16.99	21.28	−1.86
S. Schizotypal	16.02	20.10	16.52	20.30	16.34	20.22	−0.20
C. Borderline	14.88	16.66	16.29	18.46	15.54	17.56	−0.64
P. Paranoid	19.61	21.96	21.48	24.54	20.53	23.26	−0.64
A. Anxiety	23.85	25.86	22.74	24.93	23.17	25.34	0.35
H. Somatoform	17.87	23.55	16.62	20.88	17.32	22.28	0.45
N. Bipolar: Manic	33.62	21.39	34.15	22.66	33.87	22.10	−0.19
D. Dysthymic	15.49	19.92	12.36	15.70	13.86	17.92	1.40
B. Alcohol Dependence	25.50	20.25	24.05	25.54	24.68	23.04	0.50
T. Drug Dependence	29.98	21.03	29.36	22.74	29.54	21.89	0.23
R. Posttraumatic Stress	15.06	17.62	18.92	20.73	16.98	19.30	−1.61
SS. Thought Disorder	15.02	19.60	13.90	16.85	14.39	18.21	0.49
CC. Major Depression	12.82	18.58	13.32	18.12	13.10	18.32	−0.22
PP. Delusional Disorder	20.53	23.21	19.55	25.81	19.99	24.50	0.32

***$p < .001$

significant, only Scale 4 (Histrionic) involved females scoring in the clinically significant range (i.e., BR $\geq$ 75) and the mean for females approached clinical significance on Scale 7 (BR = 72.97).

It is also interesting to note that with the exception of Scales Y, 4, 5, and 7, the mean BR scores for all MCMI-III scales were extremely low for both males and females. The typical scale had a mean BR score that fell below BR = 35, which is well below the clinical median level of BR = 60. It may be recalled that a BR score of 60 served as one of the anchor points for converting raw scores to BR scores during development of the MCMI-III and this level represents the median raw score from the MCMI-III normative sample (Millon, 1994). Also, a BR score of 35 was observed to be the mean scale elevation for nonclinical populations on the MCMI-II (Millon, 1987). Thus, child custody examinees yielded mean MCMI-III scores on all scales, except Y, 4, 5, and 7, that were at levels which are similar to those found in nonclinical samples in the MCMI literature.

To examine the issue of whether or not the MCMI-III overpathologizes child custody examinees, we conducted a detailed examination of the frequency with which subjects yielded clinically significant elevations on each of the scales at varying BR score cutoffs. In Table 3, the frequency with which males, females, and the total sample scored above or below a particular BR score is provided in the form of percentages. In the first two columns of Table 3, the prevalence rate data used to anchor MCMI-III BR scores at the 75 and 85 level are listed for the *presence* and *prominence*, respectively, of personality disorders and clinical syndromes. These values are noteworthy because the MCMI-III BR scores were calculated so that elevations at or above a BR of 75 and 85 would occur at a frequency that is equal to the prevalence rates at which a personality disorder or clinical syndrome was rated as present or prominent, respectively. If the MCMI-III overpathologizes child custody examinees unfairly, then the frequency of elevations at various BR scores should be higher than those prevalence rates in the MCMI-III normative sample, assuming that personality disorders and clinical syndromes do not occur at rates greater than those observed in child custody evaluation settings as opposed to a general clinical setting.

A survey of the results in Table 3 reveals that with the exception of Scales Y, 4, and 7, the percentage of elevations above a BR of 75 and 85 are equal to or well below the prevalence rates cited in the MCMI-

TABLE 3. Percentage of MCMI-III Scale Elevations at Various BR Scores*

Scale	BR ≥ 75 Prev.**	BR ≥ 85 Prev.**	BR ≤ 75	BR ≥ 75	BR ≥ 85	BR ≥ 90	BR ≥ 95	BR ≥ 100	BR ≥ 105
X. Disclosure	28	12							
Males			100	0	0	0	0	0	0
Females			> 99	< 1	< 1	< 1	< 1	< 1	0
Total Sample			> 99	< 1	0	0	0	0	0
Y. Desirability	26	9							
Males			47	53	18	11	4	3	0
Females			52	48	17	10	2	2	0
Total Sample			50	50	17	10	3	2	0
Z. Debasement	31	14							
Males			100	0	0	0	0	0	0
Females			98	2	2	< 1	0	0	0
Total Sample			> 99	< 1	< 1	< 1	0	0	0
1. Schizoid	19	5							
Males			98	2	0	0	0	0	0
Females			98	2	< 1	< 1	< 1	0	0
Total Sample			98	2	< 1	< 1	< 1	0	0
2A. Avoidant	27	9							
Males			97	3	0	0	0	0	0
Females			98	2	< 1	< 1	< 1	0	0
Total Sample			97	3	< 1	< 1	< 1	0	0
2B. Depressive	36	14							
Males			97	3	0	0	0	0	0
Females			98	2	< 1	0	0	0	0
Total Sample			97	3	< 1	0	0	0	0
3. Dependent	48	14							
Males			96	4	< 1	< 1	0	0	0
Females			91	9	5	4	3	< 1	0
Total Sample			93	7	3	2	< 1	< 1	0
4. Histrionic	21	10							
Males			81	19	8	6	0	0	0
Females			41	59	38	28	20	7	2
Total Sample			61	39	23	17	10	3	< 1

Scale	BR ≥ 75 Prev.**	BR ≥ 85 Prev.**	BR ≤ 75	BR ≥ 75	BR ≥ 85	BR ≥ 90	BR ≥ 95	BR ≥ 100	BR ≥ 105
5. Narcissistic	21	8							
Males			84	16	4	2	< 1	< 1	0
Females			72	28	10	5	4	< 1	0
Total Sample			78	22	7	4	2	< 1	0
6A. Antisocial	17	7							
Males			98	2	< 1	0	0	0	0
Females			98	2	< 1	0	0	0	0
Total Sample			98	2	< 1	0	0	0	0
6B. Sadistic	4	1							
Males			97	3	0	0	0	0	0
Females			98	2	2	2	2	0	0
Total Sample			98	2	< 1	< 1	< 1	0	0
7. Compulsive	21	4							
Males			81	19	6	4	0	0	0
Females			47	53	21	8	3	< 1	0
Total Sample			64	36	14	6	2	< 1	0
8A. Negativistic	27	8							
Males			>99	< 1	0	0	0	0	0
Females			98	2	0	0	0	0	0
Total Sample			98	2	0	0	0	0	0
8B. Self-Defeating	30	7							
Males			98	2	< 1	0	0	0	0
Females			94	5	2	0	0	0	0
Total Sample			97	3	2	< 1	< 1	0	0
S. Schizotypal	13	3							
Males			100	0	0	0	0	0	0
Females			100	0	0	0	0	0	0
Total Sample			100	0	0	0	0	0	0
C. Borderline	27	10							
Males			100	0	0	0	0	0	0
Females			> 99	< 1	< 1	< 1	< 1	< 1	0
Total Sample			> 99	< 1	< 1	< 1	< 1	0	0

TABLE 3 (continued)

	Scale	BR ≥ 75 Prev.**	BR ≥ 85 Prev.**	BR ≤ 75	BR ≥ 75	BR ≥ 85	BR ≥ 90	BR ≥ 95	BR ≥ 100	BR ≥ 105
P.	Paranoid	13	4							
	Males			> 99	< 1	0	0	0	0	0
	Females			> 99	< 1	0	0	0	0	0
	Total Sample			> 99	< 1	0	0	0	0	0
A.	Anxiety	62	–							
	Males			89	11	< 1	0	0	0	0
	Females			90	10	< 1	0	0	0	0
	Total Sample			90	10	< 1	0	0	0	0
H.	Somatoform	16	–							
	Males			> 99	< 1	0	0	0	0	0
	Females			100	0	0	0	0	0	0
	Total Sample			> 99	< 1	0	0	0	0	0
N.	Bipolar: Manic	9	–							
	Males			100	0	0	0	0	0	0
	Females			> 99	< 1	< 1	< 1	< 1	< 1	0
	Total Sample			> 99	< 1	< 1	< 1	< 1	< 1	0
D.	Dysthymic Disorder	36	–							
	Males			98	2	0	0	0	0	0
	Females			100	0	0	0	0	0	0
	Total Sample			99	1	0	0	0	0	0
B.	Alcohol Dependence	12	–							
	Males			98	2	0	0	0	0	0
	Females			100	0	0	0	0	0	0
	Total Sample			> 99	< 1	0	0	0	0	0
T.	Drug Dependence	8	–							
	Males			97	3	0	0	0	0	0
	Females			97	3	2	2	0	0	0
	Total Sample			97	3	1	< 1	0	0	0
R.	Posttraumatic Stress	9	–							
	Males			> 99	< 1	0	0	0	0	0
	Females			100	0	0	0	0	0	0
	Total Sample			> 99	< 1	0	0	0	0	0

Scale	BR ≥ 75 Prev.**	BR ≥ 85 Prev.**	BR ≤ 75	BR ≥ 75	BR ≥ 85	BR ≥ 90	BR ≥ 95	BR ≥ 100	BR ≥ 105
SS. Thought Disorder	9	-							
Males			100	0	0	0	0	0	0
Females			> 99	< 1	0	0	0	0	0
Total Sample			> 99	< 1	0	0	0	0	0
CC. Major Depression	22	-							
Males			100	0	0	0	0	0	0
Females			> 99	< 1	< 1	< 1	< 1	0	0
Total Sample			> 99	< 1	< 1	< 1	< 1	0	0
PP. Delusional Disorder	3	-							
Males			100	0	0	0	0	0	0
Females			97	3	2	2	< 1	0	0
Total Sample			98	2	< 1	< 1	< 1	< 1	0

*Totals may not equal 100% due to rounding.
**Data are from MCMI-III manual (Millon, 1994).

III manual. With respect to Scale 4 (Histrionic), males yielded elevations that were similar to the presence (i.e., BR ≥ 75) and prominence (i.e., BR ≥ 85) rate of histrionic personality disturbances in the MCMI-III normative sample that also occurred at the BR ≥ 75 and BR ≥ 85 level, respectively. However, females yielded elevations on Scale 4 at rates that exceeded the normative sample BR cutoff rates. It was not until females, as a group, achieved BR scores of 95 or above that the frequency of Scale 4 elevations was about equal to the prevalence rate for presence of histrionic personality disorder traits. A BR score of 100 or above for the female group yielded Scale 4 elevation frequencies that were about equal to the rate for prominence of histrionic personality disturbances. Similarly, Scale 7 (Compulsive) elevations for males yielded frequencies at BR ≥ 75 and BR ≥ 85 that were essentially equivalent to those found in the MCMI-III normative sample. However, females produced a slightly greater frequency of Scale 7 elevations, with BR ≥ 85 and BR ≥ 95 reflecting frequencies that were equivalent to those found in the MCMI-III normative sample for presence and prominence of compulsive personality disorder traits, respectively.

DISCUSSION

The findings from this normative study reveal that the mean MCMI-III profile for child custody examinees was a Scale Y elevation, which reflects a socially desirable response set. There were subclinical elevations on Scales 4, 5, and 7 in the entire sample and moderate elevations on Scales 4 and 7 among females. These results are not surprising, given that there are high correlations between Scale Y and Scales 4 ($r = 0.62$), 5 ($r = 0.73$), and 7 ($r = 0.62$) as reported in the MCMI-III manual (Millon, 1994; Millon, Davis, & Millon, 1997). Research also reveals that Scales 4, 5, and 7 correlate in the positive direction with measures of emotional health and in the negative direction with measures of psychological disturbance or maladjustment (Craig, 1997; Craig & Weinberg, 1993). In studies that have used control groups of presumably well-adjusted individuals (e.g., clergy, Air Force pilots, college students), Scales 4, 5, and 7 tend to be elevated. Therefore, moderate elevations on these scales in child custody litigants are not necessarily indicative of personality pathology.

Moreover, the finding of a socially desirable response set as the mean MCMI-III profile in child custody cases was consistent with results from other studies on response patterns of child custody examinees on standardized self-report instruments (Bathurst, Gottfried, & Gottfried, 1997). Furthermore, the results of this study revealed that very low BR scores across most MCMI-III scales is common in child custody settings. Elevations on severe personality (i.e., Scales S, C, and P) and severe clinical syndrome (i.e., Scales SS, CC, and PP) scales are very infrequent occurrences. As such, the findings reveal that in general the MCMI-III does not overpathologize individuals taking the test during the course of a child custody evaluation.

Among females, there are two scales that are exceptions to this general conclusion and these scales warrant caution when they are interpreted in child custody evaluations. On Scales 4 and 7, females produced a higher frequency of elevations. We are unaware of any research that indicates histrionic and compulsive personality disorders are more prevalent in child custody settings than they are in general clinical settings. Therefore, to reduce the likelihood of false positive errors in which a person is viewed as having pathological levels of histrionic or compulsive personality traits, an adjustment in BR scores may be warranted when interpreting Scales 4 and 7 for females in child

custody cases. The normative data from this study suggest that for females only, Scale 4 scores could be reduced by about 15 BR points and that Scale 7 scores could be reduced by about 10 BR points. This process of developing MCMI-III profile adjustments is the same used by Millon in his development of the four profile adjustments based on disclosure level, response style, personality style, and inpatient status (Millon, Davis, & Millon, 1997). Since the MCMI-III scoring programs do not currently take such adjustments into account in child custody cases, the clinician should remain aware that modest elevations on Scales 4 and 7 are common in these cases and are not necessarily indicative of personality pathology. Unadjusted elevations in the BR = 75 to 85 range could instead reflect socially desirable personality characteristics associated with Scales 4 (i.e., sociability, makes friends easily, etc.), 7 (i.e., rule oriented, hard-working, conscientious, etc.), and to a lesser extent Scale 5 (i.e., confidence, self-assurance, etc.). For this reason, the MCMI-III interpretive reports should be used with extreme caution in child custody settings. In any case, the adjustments noted above can be used flexibly and interpretation of MCMI-III results should integrate data from the person's history, other test results, collateral reports, and observations of parent-child interactions.

It is also worth noting that the comparisons of MCMI-III scale elevation frequencies for child custody examinees against the clinical prevalence rates in the MCMI-III manual may be viewed by some individuals as inappropriate. That is, some may argue that child custody evaluations are not clinical in nature. This issue is beyond the scope of this paper, but we believe there are several reasons to view child custody examinations as clinical assessments because stress and conflict generated over disputes involving custody of children frequently produce an intensification of inflexible and maladaptive coping strategies that may constitute an exacerbation of subclinical personality disturbances. Moreover, highly conflicted and contentious child custody disputes place a burden on the clinician conducting such evaluations to consider the possibility that psychopathology or clinical symptoms may be present and their impact on parenting must be considered. However, for those who do not subscribe to the view of child custody evaluations being clinical in nature, we have provided sufficient normative data in Tables 2 and 3 to permit clinicians to define their own BR cutoffs based on prevalence rates that are believed to be more representative of child custody settings. Another

comparable strategy would be to uniformly adopt a more conservative BR cutoff (e.g., BR $\geq$ 85 or BR $\geq$ 90 without adjustments) for those scales associated with a socially desirable response set, including Scales Y, 4, and 7 and to a lesser extent Scale 5.

Results from this study provide empirical support for the position that the MCMI-III does not overpathologize individuals who take the test as part of a child custody evaluation. While Scales 4 and 7 tend to over represent the severity of histrionic and compulsive personality traits in females, we suggest some adjustments that may reduce the number of false positive diagnoses on these scales. Moreover, while cross-validation of these findings is encouraged, there is support for their generalizability in that subjects were selected from four different states and were actually involved in a child custody dispute that was being adjudicated.

The findings from this study also provide an empirical foundation to support continued use of the MCMI-III in child custody evaluations for those clinicians who feel that this instrument provides useful diagnostic information in such contexts. The MCMI-III can be useful to screen for various personality disorders and clinical syndromes that may have an impact on parenting or visitation. The presence or absence of psychopathology is not solely determinative of whether or not a parent should ultimately be granted custody. Furthermore, the clinician must integrate psychological test results with other data that address these issues and we endorse the use of other assessment techniques, in addition to the MCMI-III, that evaluate relevant issues in child custody evaluations, such as those directly related to parenting and the quality of the parent-child relationship. Toward that end, in the future we plan to examine the relationship between MCMI-III results and relevant external criteria, such as legal outcome and reports of domestic violence.

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