Psychological Assessment in South Africa

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Theodore Millon (1969; 1991; 1994; 1996b; 2010) argues that predominant theories of personality tend to focus primarily on either the intrapsychic, interpersonal, environmental or biological aspects involved in personality development. Instruments, particularly objective, self-report questionnaires, are then developed in relation to these theories to assess personality. However, personality is more than just intrapsychic or interpersonal factors.

Millon attempts to combine the intrapsychic, cognitive and interpersonal spheres in his theory. He also acknowledges that an integrated approach needs to go beyond psychology if it is to be truly holistic (Millon, 1996b). In keeping with this argument, he borrows from evolutionary biology to develop his biopsychosocial evolutionary theory of personality, which underpins a number of instruments developed under the Millon umbrella.

The Millon family of instruments consists of pre-adolescent, adolescent, adult and medical patient inventories. The Millon Pre-Adolescent Clinical Inventory (M-PACI) is a comprehensive clinical tool that is designed to quickly and accurately identify psychological problems in children between the ages of 9 and 12. Unlike other instruments that focus on single clinical areas such as depression or anxiety, the M-PACI provides a synthesis of the child’s emerging personality style and clinical syndrome, and can assist with early intervention (Millon, 2010). The Millon Adolescent Personality Inventory (MAPI) is a measure that assesses eight personality style dimensions, expressed concerns and behavioural correlates in normal adolescents aged 13 to 18 years (Millon, 2010). The Millon Adolescent Clinical Inventory (MACI) was developed specifically for use in regard to diagnostic assistance, treatment formulation and outcome measure in the clinical setting, and is used primarily for the evaluation of adolescents with difficulties. The MACI supplements the MAPI in providing a more holistic picture of the adolescent’s personality type and clinical difficulties that he or she may be experiencing (Millon, 2010).

The Millon Inventories also include the Millon College Counselling Inventory (MCCI), Millon Behavioural Medicine Diagnostic (MBMD) and Personality Adjective Check List (PACL). The MCCI is an assessment tool that can help address students’ concerns and student-specific issues such as depression, stress, anxiety, substance abuse, suicidal ideation, and adjustment and relationship difficulties (Millon, 2010). The MBMD provides medical and
health practitioners with an assessment of psychosocial factors that may support or interfere with a chronically ill patient’s medical treatment (Millon, 2010). The MBMD is used to identify significant psychiatric problems, as well as to identify personal and social assets that may facilitate a patient’s adjustment to his or her physical limitations and lifestyle changes (Millon, 2010). Finally, the PACL is a measure of Millon’s eight basic personality types for use in normal adults. The measure is appropriate for use in individuals who are 16 years and older, and is frequently used by psychologists who want to achieve a rapid understanding of their clients’ strengths and weaknesses. The PACL is used in relatively higher-functioning individuals (Millon, 2010). The Millon Index of Personality Styles – Revised (MIPS-Revised) and Millon Clinical Multiaxial Inventory – III (MCMI-III) are designed for use on the adult population.

Millon’s theory

In a book published more than 40 years ago, Theodore Millon proposed a theoretical grid for the classification of personality (Millon, 1969). Part of the appeal of his proposal was that it grouped together eight different personality prototypes that had long been recognised by clinicians. The scheme leading to the prototypes was eventually revised to consist of three polarities, tendencies that theoretically resulted in the distinguishing characteristics of the different personality prototypes – namely, pain vs pleasure, active vs passive, and self vs other (Millon, 1994; 1996b). The theory influenced the development of the current classification of personality disorders by the American Psychological Association and has led to the creation of four different psychological instruments, of which the MCMI has achieved widespread use with psychiatric patients (Choca, 1998).

According to Millon (1996a, p.13), personality is

[an] inferred abstraction, a concept or construct, rather than a tangible phenomenon with material existence ... personality may be conceived as a psychic system of structures that parallels that of the body. It is not a potpourri of unrelated traits and miscellaneous behaviors but a tightly knit organisation of stable structures (e.g. internalised memories and self images) and coordinated functions (e.g. unconscious mechanisms and cognitive processes). Given continuity in one's constitutional equipment and a narrow band of experiences for learning behavioral alternatives, this psychic system develops an integrated pattern of characteristics and inclinations that are deeply etched, cannot be easily eradicated, and pervade every facet of their life experience ...

Thus, according to Millon, personality is that abstract concept that consists of an individual’s lifelong style of relating, coping, behaving, thinking and feeling.

Based on this, then, one is inclined to conclude that psychopathology is the condition that arises as a result of any internal or external factor that upsets or is incoherent with an individual’s lifelong style of relating, coping, behaving, thinking and feeling. Millon (1996a) argues that there is no sharp line that
Section Two: Personality and Projective Tests

divides normal from pathological behaviour. According to him, they are relative concepts representing arbitrary points on a continuum. Millon’s conception of normality and psychopathology is best represented in Figure 21.1.

**Figure 21.1** Millon’s continuum of personality development

From Figure 21.1, it becomes clear that normality and psychopathology are opposite ends of a continuum, and it is possible to experience varying degrees of normality and psychopathology. When an individual displays an ability to cope with the environment in a flexible manner, and when his or her typical perceptions and behaviours foster increments in personal satisfaction, then the individual may be said to have a normal or healthy personality. The most common criterion used to determine normality is a statistical one, in which normality is determined by those behaviours that are found most frequently in a social group; and pathology or abnormality, by features that are uncommon in that population. Among diverse criteria used to signify normality are a capacity to function autonomously and competently, a tendency to adjust to one’s environment effectively and efficiently, a subjective sense of contentment and satisfaction, and the ability to self-actualise or to fulfil one’s potentials. Psychopathology would be noted by deficits among these features. Thus psychopathology reflects the person–environment interaction, and types of psychopathology can be distinguished in terms of the extent to which their determinants derive from personological versus situational forces (Millon, 1996a).

Personality disorders (Axis II)¹ are best conceived as those conditions that are ‘activated’ primarily by internally embedded structures and pervasive ways of functioning. At the opposite end of the internal–external continuum are the adjustment reactions, which are best construed as specific pathological responses attributable largely to circumscribed environmental precipitants. Between these polar extremes lie the categories of psychopathology that are anchored more or less equally and simultaneously to internal personal attributes and external situational events. These are referred to as clinical syndromes (Axis I)² (Millon, 1996a). This is best represented in Figure 21.2.

**Figure 21.2** Millon’s conceptualisation of the role of personological and situational factors

<table>
<thead>
<tr>
<th>INTERNAL/PERSONOLOGICAL FACTORS</th>
<th>EXTERNAL/SITUATIONAL FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PERSONALITY DISORDERS</td>
<td>CLINICAL SYNDROMES</td>
</tr>
<tr>
<td>CLINICAL SYNDROMES</td>
<td>NORMAL PERSONALITY</td>
</tr>
<tr>
<td>CLINICAL SYNDROMES</td>
<td>ADJUSTMENT DISORDERS</td>
</tr>
</tbody>
</table>
From the discussion thus far it becomes possible to conclude that Millon, unlike some of his predecessors, adopts a holistic view of personality and psychopathology. He regards both personality and psychopathology as being products of the person–environment interaction, and does not subscribe to a wholly intrapsychic or wholly interpersonal approach. Rather, he adopts an integrative theory of personality and psychopathology in which he stresses that ‘biological and experiential determinants combine and interact in a reciprocal interplay throughout life ... Etiology in psychopathology may be viewed, then, as a developmental process in which intraorganismic and environmental forces display not only a reciprocity and circularity of influence but an orderly and sequential continuity throughout the life of an individual’ (Millon, 1996c, p.59). This forms the basis for Millon’s biosocial learning approach towards personality and psychopathology.

In 1990, Millon published *Toward a New Personology: An Evolutionary Model*. In this book he extended his theory to include normal individuals. The MIPS represents an extension of the Millon assessment tools into the measurement of ‘normal’ individuals. Millon’s theory takes evolutionary biology as a point of departure, and then amalgamates concepts from other theorists – Freud, Jung and Leary – as well as some theoretical contributions from the Five-Factor Model. He considers personality to be composed of the nature, the source and the instrumental behaviours that an individual exhibits. Rather than giving primacy either to the ‘driving’ motivational and emotional roots of personality style (as in Millon’s formulation of personality disorders or Freudian theory), or to the overt behavioural expressions of personality (as explicated in the Five-Factor Model, for example), the Millonian approach seeks to conjoin these components by linking them to cognitive functions. In this way, he attempts to integrate the various components of personality into a single coherent whole under the umbrella of evolutionary principles (Millon, 1994).

In accordance with evolutionary psychology, Millon likens the development of an individual’s personality to the ontogenetic development of that individual organism’s adaptive strategies (Million, 1994; 1996d). Just as an individual organism begins life with a limited subset of its species’ genes and the trait potentials they subserve, an individual is also born with a number of potential personality styles. Over time, the salience of these trait potentials – not the proportion of the genes themselves – will become differentially prominent as the organism interacts with its environments. Thus with time, as the individual adapts to his or her environment, different personality styles will become differentially prominent and latent potentialities will be shaped into adaptive and manifest styles of perceiving, feeling, thinking and acting. It is these distinctive modes of adaptation, engendered by the interaction of biological endowment and social experience, that Millon (1991; 1994; 1996d) identifies as ‘personality styles’.

In the South African context, we were only able to locate research on the MIPS-Revised and the MCMI-II and MCMI-III. Hence these instruments are focused on in this chapter.
The MIPS

The MIPS-Revised represents an extension of the Millon assessment tools into the measurement of ‘normal’ individuals. Millon attempts to combine the intrapsychic, cognitive and interpersonal spheres in his theory. However, Millon also acknowledges that an integrated approach needs to go beyond psychology if it is to be truly holistic. In keeping with this argument, he borrows from evolutionary biology to develop his theory. He identifies 24 different characteristics or 12 bipolar traits that can be grouped in numerous different ways to describe an individual’s personality style. These 12 bipolar traits are organised into categories such that they represent motivational, cognitive and interpersonal characteristics. Millon’s theory thus considers three motivational aims bipolarities, four cognitive modes bipolarities and five interpersonal behaviours bipolarities (see Figure 21.3). These bipolarities are assessed using the MIPS. The MIPS also includes two scales labelled Positive Impression and Negative Impression to measure the test-taking attitude of the examinee. A third Consistency scale establishes the consistency of responses across the questionnaire.

The utility of the MIPS was explored in the South African setting in a sample of 245 university students (Laher, 2001). According to Laher (2001), the descriptive statistics, norms and reliability coefficients obtained in the study were highly satisfactory, as well as comparable to the US norms. Comparable interscale correlations, together with a factor structure that factors into five factors consonant with the Five-Factor Model, were also found. Laher (2001) argued that while the findings of her study lent support to the cross-cultural applicability of the instrument, other evidence from the criterion, content and construct validity explorations indicated that there were differences in the expression of the factors across cultures, and that the factors presented by Millon were not exhaustive. There were other factors which Millon’s model, by virtue of being located in a Eurocentric framework, did not take into account. In 2007, Laher published a paper on the Millon approach to personality and demonstrated that whilst the model was theoretically sound, it was not complete. It failed to take into account the environment and, more importantly, cultural differences in its understanding of personality. As such, its utility in a diverse South African culture is debatable (Laher, 2007).

The MCMI-III

The MCMI-III (1997) is a clinical tool, and the primary intent of this assessment inventory is to provide clinical information to professionals about a person’s emotional and interpersonal difficulties (Millon, 2010). In the South African context the MCMI-III is employed frequently in both clinical and counselling settings (Foxcroft & Roodt, 2005). It is the only test in the Millon family of instruments that is widely used and researched in South Africa (Foxcroft, Paterson, Le Roux & Herbst, 2004). This instrument is therefore discussed in more detail here, and South African research on the instrument is presented.
Figure 21.3 Diagrammatic representation of Millon’s theory of normal personality

- **PERSONALITY**
  - **MOTIVATING AIMS**
    - **Existence**
      - Preserving (1a)
        - (Pain-avoiding)
      - Enhancing (1b)
        - (Pleasure-enhancing)
    - **Adaptation**
      - Modifying (2a)
        - (Actively modifying)
      - Accommodating (2b)
        - (Passively accommodating)
    - **Replication**
      - Individuating (3a)
        - (Self-indulging)
      - Nurturing (3b)
        - (Other-nurturing)

- **COGNITIVE MODES**
  - **Sources of information**
    - Extraversing (4a)
      - (Externally focused)
    - Introversing (4b)
      - (Internally focused)
    - Sensing (5a)
      - (Realistic-sensing)
    - Intuiting (5b)
      - (Imaginative-intuiting)
    - Thinking (6a)
      - (Thought-guided)
    - Feeling (6b)
      - (Feeling-guided)
    - Systematising (7a)
      - (Conservation-seeking)
    - Innovating (7b)
      - (Innovation-seeking)

- **INTERPERSONAL BEHAVIOURS**
  - Retiring (8a)
    - (Asocial/Withdrawing)
  - Outgoing (8b)
    - (Gregarious/Outgoing)
  - Hesitating (9a)
    - (Anxious/Hesitating)
  - Asserting (9b)
    - (Confident/Asserting)
  - Dissenting (10a)
    - (Unconventional/Dissenting)
  - Conforming (10b)
    - (Dutiful/Conforming)
  - Yielding (11a)
    - (Submissive/Yielding)
  - Controlling (11b)
    - (Dominant/Controlling)
  - Complaining (12a)
    - (Dissatisfied/Complaining)
  - Agreeing (12b)
    - (Cooperative/Agreeing)
The MCMI-III is a self-report instrument designed to help the clinician assess Axis I disorders (clinical syndromes) and Axis II disorders (personality disorders) based on the DSM-IV-TR (APA, 2004) classification system. Published in 1994, the MCMI-III consists of 175 true-false items, and is appropriate for use on individuals who are 18 years and older and who have at least an eighth-grade reading level. It is used primarily in clinical and counselling settings with individuals who require mental health services for emotional, social or interpersonal difficulties. It can assist in diagnosis, and in developing a treatment plan that takes into account the patient's personality style and coping behaviour. It consists of 11 clinical personality pattern scales, 3 severe personality pathology scales, 7 clinical syndrome scales, 3 severe syndrome scales and 3 modifying indices, as described in Table 21.1.

**Table 21.1 Structure of the MCMI-III**

<table>
<thead>
<tr>
<th>Clinical personality patterns</th>
<th>These scales assess the personality of an individual that cuts across the established personality prototypes and that demonstrates a different level of extremeness on any of the given personality patterns.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizoid</td>
<td>Individuals who are expressively impassive and interpersonally unengaged. They display a lifelong pattern of social withdrawal, feel uncomfortable with human interaction and are often seen as eccentric, isolated or lonely.</td>
</tr>
<tr>
<td>Avoidant</td>
<td>Individuals who are expressively fretful and interpersonally aversive. They are extremely sensitive to rejection that leads to social withdrawal. Although shy they have a strong desire for companionship.</td>
</tr>
<tr>
<td>Depressive</td>
<td>Individuals who are expressively disconsolate and interpersonally defenceless. They are characterised by lifelong traits that fall under the pessimistic, anhedonia, self-doubting and chronically unhappy spectrum.</td>
</tr>
<tr>
<td>Dependent</td>
<td>Individuals who are expressively incompetent and interpersonally submissive. These individuals subordinate their own needs to those of others. They lack self-confidence and may get others to assume responsibility for major areas of their lives.</td>
</tr>
<tr>
<td>Histrionic</td>
<td>Individuals who are expressively dramatic and interpersonally attention-seeking. They are excitable and emotional. They tend to behave in a dramatic and extraverted fashion, and have a high degree of attention-seeking behaviour.</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>Individuals who are expressively haughty and interpersonally exploitative. They have a heightened sense of self-importance and feelings of grandiosity. These individuals often feel unique and special.</td>
</tr>
<tr>
<td>Antisocial</td>
<td>Individuals who are expressively impulsive and interpersonally irresponsible. They have an inability to conform to social norms of expected adult behaviour. These are individuals who show a reckless disregard for self and others.</td>
</tr>
<tr>
<td>Aggressive (sadistic)</td>
<td>Individuals who are expressively reckless, reactive and interpersonally abrasive and coercing. They are strongly opinionated, obstinate and closed-minded and are prone to a hostile mood.</td>
</tr>
</tbody>
</table>
### The Millon Inventories in South Africa

**Clinical personality patterns**

These scales assess the personality of an individual that cuts across the established personality prototypes and that demonstrates a different level of extremeness on any of the given personality patterns.

<table>
<thead>
<tr>
<th>Compulsive</th>
<th>Individuals who are expressively disciplined and interpersonally respectful. They exhibit unusual compliance with social conventions and can be over-conscientious. They will adhere to rigid hierarchies and can become upset by the unfamiliar.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Passive-Aggressive (Negativistic)</td>
<td>Individuals who are resentful and are characterised by covert obstructionism, procrastination, stubbornness and inefficiency. Such behaviour is the manifestation of passively expressed underlying aggression.</td>
</tr>
<tr>
<td>Self-defeating (masochistic)</td>
<td>Individuals who are expressively non-indulgent and interpersonally distant from those who are consistently supportive. They can be simultaneously anxiously apprehensive and, on the other hand, mournful and forlorn.</td>
</tr>
</tbody>
</table>

**Severe personality pathology**

These scales determine how functional an individual is. An elevation on this scale represents a dysfunctional personality disorder.

<table>
<thead>
<tr>
<th>Schizotypal</th>
<th>Individuals who are peculiar in their mannerisms and are reticent with others. They use magical thinking as a consistent manner of defence and are haphazard and chaotic.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Borderline</td>
<td>Individuals who are dysfunctional, with abrupt shifts in behaviour and interpersonal relationships. These individuals lack an identity consolidation and are characterised by unstable and fluctuating moods that range from euphoria to profound despair.</td>
</tr>
<tr>
<td>Paranoid</td>
<td>Individuals who are characterised by long-standing suspiciousness and mistrust of others. They will assign their own feelings of hostility, anger and irritability to others.</td>
</tr>
</tbody>
</table>

**Clinical syndromes**

These scales are an extension or distortion of the individual’s basic personality pattern. They represent symptoms that can occur within any personality type. They are more transient over time and are psychometrically less stable than the personality traits.

<table>
<thead>
<tr>
<th>Anxiety</th>
<th>Relates to an individual’s experience of tension, restlessness, possible phobic responses, some physiological symptoms of anxiety and worry.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somatoform</td>
<td>Relates to complaints of fatigue, pains, aches and strange sensory experiences.</td>
</tr>
<tr>
<td>Bipolar-Manic</td>
<td>Degree to which the individual reports elation, overactivity, impulsiveness, flight of ideas and rapid shift in moods.</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>Relates to feelings of guilt, dejection, futility, pessimism, problems with concentration and decreased interest in the interpersonal world.</td>
</tr>
<tr>
<td>Alcohol dependence</td>
<td>Detects the presence of alcohol use and dependence.</td>
</tr>
<tr>
<td>Drug dependence</td>
<td>Detects the presence of substance use and dependence.</td>
</tr>
<tr>
<td>Post-Traumatic Stress Disorder</td>
<td>Relates to the painful re-experiencing of a traumatic event, coupled with patterns of avoidance and emotional numbing. Also detects constant hyper-arousal in a person.</td>
</tr>
<tr>
<td><strong>Severe syndromes</strong></td>
<td><strong>These scales assess more severe symptomatic psychopathology.</strong></td>
</tr>
<tr>
<td>----------------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>Thought Disorder</td>
<td>Represents symptoms of schizophrenia, schizophreniform disorder or brief reactive psychosis.</td>
</tr>
<tr>
<td>Major Depression</td>
<td>Assesses the presence of a profoundly debilitating depressive disorder.</td>
</tr>
<tr>
<td>Delusional Disorder</td>
<td>Identifies paranoid individuals with a psychotic level of symptomatic presentation. These individuals are likely to have systemised delusions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Modifying indices</strong></th>
<th><strong>These are scales that assess the validity of the MCMI-III profile.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Desirability Scale</td>
<td>Determines the patient’s inclination to be socially attractive.</td>
</tr>
<tr>
<td>Debasement Scale</td>
<td>Detects a tendency to devalue oneself by presenting more troublesome emotional problems.</td>
</tr>
<tr>
<td>Validity Scale</td>
<td>Includes three bizarre or highly improbable items to see if responses throughout are valid.</td>
</tr>
</tbody>
</table>

**Psychometric properties**

Millon’s normative sample for the MCMI-III consisted of 998 males and females, including patients seen in independent practices, clinics, mental health centres, residential settings and hospitals. Since the norms are based on clinical samples, the instrument is not appropriate for use with nonclinical populations.

An important feature of the MCMI-III is its use of base rate scores for norms. Unlike other instruments which calculate norms based on the normal distribution, the MCMI-III uses the clinical prevalence rates in a particular population. Thus there is no assumption that a particular pathology is normally distributed in a population.

Both internal consistency and test-retest reliability are demonstrated in the MCMI-III. Internal consistency for the personality scales ranged from .66 to .90 (N = 398), with alphas exceeding .80 for 20 of the scales. Test-retest reliability coefficients ranged from .82 to .96 (Millon, 1997).

The MCMI-III appears to have good concurrent validity with a wide variety of other personality tests – namely, Beck’s Depression Inventory, the General Behaviour Inventory, the Symptom Checklist 90 – Revised and the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), as well as with the MCMI-II (Dyce, O’Connor, Parkins & Janzen, 1997; Millon, 1997). It was also found to correlate well with other tests – namely, the Michigan Alcoholism Screening Test, the Impact of Events Scale and the State-Trait Anxiety Inventory. Similar findings have been reported between the MCMI and the more narrowly bound instruments, including the Profile of Mood States, the General Health Questionnaire and the Interpersonal Checklist (Millon, 1997).

**Cultural considerations**

The MCMI-III is frequently employed within the South African clinical setting. As such, it is important that its cross-cultural utility be explored within this context in both South African and non-Western cultures.

A Dutch study of 263 inpatient substance abusers looked at establishing cross-cultural equivalence in the MMPI as well as the MCMI-III (Egger, De Mey, Derksen & Van der Staat, 2003). The aim was to establish cross-cultural equivalence across
both instruments and per instrument. Egger et al. (2003) found cross-cultural similarities in a component-by-component comparison between the MMPI and the MCMI-III. However, the findings also suggest that the MCMI-III itself showed a limited degree of cross-cultural similarity, leading the researchers to argue that the influence of translation as well as cultural differences cannot be overlooked when using the MCMI-III. On the other hand, a Chinese study that examined the MCMI-III profile of 107 substance abusers at a psychiatric institution in Hong Kong found good predictive validity between the MCMI-III scales and Axis I and Axis II pathologies. This study used the Chinese version of the MCMI-III that had been back-translated into English to account for reduced influence of translation on the outcome of the study (So, 2005).

Benjamin (2006) used the MCMI-II in a study on compliance with chemotherapy in a sample of 134 oncology patients at the Johannesburg General Hospital in South Africa. Significant differences were found between compliant and non-compliant patients on the Disclosure, Debasement, Avoidance, Passive-Aggressive, Self-defeating, Schizotypal, Anxiety, Dysthymia, Alcohol Dependence and Major Depression scales. The most important predictors of non-compliance were the Debasement and Schizotypal scales. Hence these were used to successfully develop a treatment intervention model that improved non-compliance: the Medical Trauma Debriefing Model. One of the features of the MCMI-III is the inclusion of a Post-Traumatic Stress scale. It would be interesting for further research to explore compliance using the model developed, together with the MCMI-III.

As part of a broader South African National Defence Force (SANDF) initiative, Naggan (2001) undertook research in an attempt to screen military personnel and to standardise the MCMI-III for the South African population. This study was conducted on 5 707 members of the SANDF who were based outside South Africa. This sample was representative of race and gender within the military context, and ranged in age from 18 to 65 years. Results found good criterion validity for the Dependent, Schizotypal, Borderline, Paranoid and Compulsive Personality scales, and, to a lesser extent, for the Antisocial and Narcissistic personality scales (Naggan, 2001).

Good criterion and predictive validity was also found in research done by Laher and Rebolo (2010), Tshabalala (2004) and Lloyd (2008). Laher and Rebolo’s (2010) study on 23 patients, gender-representative and between the ages of 22 and 68, who had been diagnosed with Bipolar Disorder, showed good predictive outcomes on the Avoidant and Passive-Aggressive scales. A study on a diverse group of 20 African military and humanitarian personnel conducted over a 14-month period found that the Depressive, Narcissistic and Anxiety scales provided good negative indicators on the competency model of civil military officials (Lloyd, 2008). This means that the MCMI-III represented meaningful scales that correlated with the competencies that were required by the members of the civil military, thus demonstrating appropriate criterion validity (Lloyd, 2008). Good predictive outcomes were also found between the personality dynamics of ten male sexual offenders on the clinical syndrome scales as well as on the personality pathology scale (Tshabalala, 2004).
However, despite these findings across the various cross-cultural studies, there are at least four aspects of the MCMI-III that need to be highlighted where culture can affect psychological disorders. The first relates to psychometrics, and considers issues of translation and, more broadly, language proficiency when using tests like the MCMI-III in a South African context. With translation, the first question would be which language the test would be translated into, since South Africa has 11 official languages. Furthermore, research on translation with other personality instruments – for example, the Sixteen Personality Factor Questionnaire (Van Eeden & Mantsha, 2007) and the NEO Personality Inventory (Horn, 2000) – has shown that problems exist with finding equivalent terms, or that there are difficulties with finding the same word in another language. For example, ‘blue’ and ‘green’ are expressed by the same word in isiXhosa. Alternatively, the meaning of a word may be different across languages. For example, ‘feeling blue’ in English means feeling sad, but an equivalent translation in Afrikaans, ‘voel blou’, means feeling tired. Further issues related to language are those of English proficiency in a country where English is the second language for most of the population. Of the 11 official languages, isiZulu is the most commonly spoken language (23.8 per cent), followed by isiXhosa (17.6 per cent), Afrikaans (13.3 per cent), Sepedi (9.4 per cent), Setswana and English (8.2 per cent), Sesotho (7.9 per cent), Xitsonga (4.4 per cent), Siswati (2.7 per cent), Tshivenda (2.3 per cent), isiNdebele (1.6 per cent) and other languages (0.5 per cent) (Statistics South Africa, 2001). Also related to language is the issue of using translators. Quite often in health-care settings, psychologists rely on nurses and other health professionals to assist with the administration of the MCMI-III, as the psychologist does not speak the language of the patient. This is done on an ad hoc basis, and from experience it is clear that the use of interpreters compromises standardisation and introduces a number of biases into the administration procedure.

Other issues of bias across various groupings also exist. This leads to the second concern, that of equivalence and the use of self-report inventories in cultures other than those in which the instruments were developed and normed. Van de Vijver and Tanzer (1997) argue that it cannot be taken for granted that scores that are obtained in one culture can be compared across cultural groups. Some cultures can be considered similar – for example, the US culture can be seen to be similar to European cultures – but one cannot make the same argument when comparing Western cultures to a country like China (Van de Vijver & Tanzer, 1997). For example, a base rate score on the Narcissistic Personality Disorder may be significantly higher in some cultures that value independence and self-directed behaviour (Rossi, Sloore & Derksen, 2008). Similarly, a study that looked at the differences between US and Korean students differed on 7 of the 11 MCMI-III scales. Korean participants scored significantly higher than their US counterparts on the Dependent scale, reflecting more passive personality orientations, whilst scoring much lower on the Histrionic scale (Gunsalus & Kelly, 2001). The use of base rate scores, whilst useful in the population on which the MCMI-III was normed, is a limitation in all other groups since it cannot be assumed that the prevalence of a particular disorder is the same in every group. As correctly pointed out by a reviewer of this chapter, accurate diagnosis rests
upon accurate estimates of base rates. Thus there is a need to develop local base rates, rather than assuming that prevalence rates are comparable in the South African context.

Similar consideration needs to be given to demographic variables of race and gender. Scores obtained on the MCMI-III between black and white psychiatric inpatients indicated a difference in predicting psychopathology between the two races (Choca, Stanley, Peterson & Van Denburg, 1990). Lindsay and Widiger (1995) argued that one has to consider that results may be more a prediction of the respondent’s gender than of personality dysfunction. In data summarised from six studies, Craig (1999) found that African-Americans consistently scored higher on the Narcissistic, Antisocial, Paranoid, Drug Dependence and Delusional Disorder scales, while Caucasian Americans scored higher on the Dysthymia scale. Furthermore, men scored higher on the Antisocial scale, whilst women scored higher on the Somatoform and Major Depression scales.

Thirdly, the way clients express or explain their problems may differ across cultures (Cheung, 2009; Craig, 2005). For many, mental illness is regarded as a test from God and something that the family and community deal with (Laher & Khan, 2011). Asian individuals tend to somaticise their symptoms more than Western individuals (Cheung, 2009). However, Cheung (2009) alerts one to the bias prevalent in Western models which discuss this tendency to somaticise psychological symptoms as pathological and characteristic of Asian cultures. She reframes it within a different taxonomy of mental illness, where somaticisation is normal and is linked to personality features that emphasise harmony and traditionalism. Cheung (2009, p.46) argues that somaticisation needs to be reconceptualised ‘as a metaphor of distress in the cultural context of an illness experience with implications to social relationships, coping and help-seeking behavior’.

Finally, what is considered to be a psychological problem can also differ between cultures (Swartz, 2002). Meyer, Moore and Viljoen (2003) cite the example of schizophrenia, which is commonly misdiagnosed in African individuals. The African belief system advocates communication with ancestors as well as the belief in spiritual illnesses linked to bewitchment. Western practitioners misdiagnose these as paranoid delusions and auditory hallucinations, leading to a misdiagnosis of schizophrenia (Meyer et al., 2003). Ally and Laher (2008) discuss how the conceptualisation of the person and the illness (medical, psychological and spiritual) differ from Western models, which are rooted in Cartesian dualism and fail to take into account a deeper, more essential layer of the person related to the spiritual essence, and how this links to medical and psychological illness.

Both Cheung (2009) and Ally and Laher (2008) argue for the need to move away from the traditional philosophy of Cartesian dualism that underlies current epistemologies of psychopathology, and advocate the consideration of other philosophies. Both studies concur that while current models are useful, and while instruments like the MCMI-III provide useful information, they are limited when used in non-Western contexts. What is also common across both articles is the emphasis on the role of community and context in the understanding, aetiology and treatment of psychological illness, and further research in this regard is warranted.
Conclusion

The MCMI-III is a psychological assessment tool that has been derived from comprehensive theory, and it has been coordinated with the format of the DSM. It enhances diagnostic efficiency by taking the base rates of the disorders that it measures into account. The MCMI-III is also very easy to administer and to interpret, allowing the clinical practitioner to use it as part of a comprehensive assessment strategy (Craig, 1999).

Based on clinical experience, a reviewer for this chapter highlighted the fact that the MCMI-III's brevity and the instrument’s correspondence with official diagnostic constructs of the DSM-IV-TR (APA, 2004) mean that it is extremely useful in formulating and communicating diagnoses and treatment plans in a multidisciplinary team setting. It is also useful in looking at the interplay between Axis I and Axis II, as well as the relationship between personality characteristics and clinical syndromes. Furthermore, the MCMI-III has been found to be very useful in that it is quick and simple to administer to patients who are distractible and who tire easily.

On the other hand, responses to the MCMI-III questionnaire are true/false, and this make the test susceptible to acquiescent response sets (Craig, 1999). It also appears to be less effective in assessing individuals with minor personality pathology, and those with very severe dysfunction such as the psychotic disorders (Craig, 1999). There may also be subtypes of different personality disorders, but assessment of these subtypes has not been incorporated into the MCMI-III (Craig, 1999). However, there is a move towards this with the Grossman Facet Subscales (Millon, 2010).

Finally, even though the MCMI-III remains a well-researched instrument, its wide use within the South African clinical and counselling context warrants that a culturally responsive approach must be very seriously considered in its application (Cheung, 2009; Cheung, Van de Vijver & Leong, 2011). Cultural differences can be relative, and may not necessarily describe levels of personality pathology; overlooking the rich diversity inherent in the South African population can mean a misdiagnosis of pathology in individuals (Meyer et al., 2003). Furthermore, ignoring the role of the community and context in the understanding, aetiology and treatment of psychological illness will further limit the use of the MCMI-III (Ally & Laher, 2008; Cheung, 2009). A universal model like the MCMI-III must be applied with caution across cultures.

Notes

1 According to DSM-IV multiaxial diagnosis (APA, 2004).
2 According to DSM-IV multiaxial diagnosis (APA, 2004).

References


