

Critical Analysis of the Millon Clinical Multiaxial Inventory

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Abstract— This paper is a critical analysis of the Millon Clinical Multiaxial Inventory. The test assesses an individual's personality and examines clinical syndromes. In this paper, we will give a description of the test. We will also go over the technical aspect of the test. We will further discuss practical use of the test. We will additionally discuss some strengths and weakness of the test. Lastly, we will discuss future research.

Index Terms— Assessment, Disorders, Inventory, Millon, Multiaxial, Personality, Test,

1 INTRODUCTION

The Millon Clinical Multiaxial Inventory is at present in its 3rd edition, has expressed quite a few groundbreaking concepts in personality and mental assessment. The MCMI-III concentrates on the differences in the diagnosis of clients, in comparison to other tests of mental health, in which client groups are assessed to normal people, not other clients. The test scales are closely related to Diagnostic and Statistical Manual of Mental Disorders (DSM) concepts whereas still preserving their commitment to Millon's own concept of personality disorder (Grove & Scott, 2009).

Test Description

The assessment is a 175-item, true-false, self-report inquiry form that measures 14 personality disorders (PDs) and 10 clinical syndromes (CSs) by means of ordinal scales that measure how copious and how well individuals correspond or match the constructs being measured. With respect to the PD scales, items are separated into two groups: one characterizing central constructs of the personality that are distinctive to that disorder and one characterizing constructs more tangential and have a tendency to be shared with one or more alike PDs. For scoring reasons, core items (similarly known as prototype items) are weighted 2, while tangential, corresponding items are weighted 1. Consequently, the highest raw scores for each PD scale are achieved by individuals who show more of the mindsets, concepts, emotions, and actions that are fundamental to the description of that personality (Strack & Millon, 2007; Drummond, Sheperis, & Jones, 2016).

To aid in diagnosing clients corresponding to the DSM-IV, PD scale items deal with major diagnostic conditions, and normative information were taken from psychiatric clients with recognized DSM-IV diagnoses. By assessing the occurrence of each condition in the test's normative sample, scale totals were converted into base rate (BR) scores that aid in classifying individuals corresponding to DSM-IV criteria. For instance, knowing that clients in the normative sample who were identified as having a schizoid PD had raw scores on the MCMI-III Schizoid scale beyond a specific point permitted Millon to form a BR cutoff score that would signal the test user to a client who was probable to meet DSM-IV criteria for a schizoid PD (Strack & Millon, 2007).

The MCMI-III PD scales made functional the standard prototypes of the model unambiguous and measurable. Scale scores are incessant but allow clear-cut diagnoses with the usage of BRs fixed to the normative sample of DSM- evaluated clients. The usage of client norms restricts the appositeness of the scales for measuring normal-range trait traits, but individuals can be distinguished as tending to be normal or disordered based on PD scale of under and over the clinically significant cutoff of BR = 75. Essentially, an outline of each person can be made to establish subtype characteristics, making for a full and multifaceted personality narrative that has a high likelihood of corresponding to clinical impressions, particularly those centered on social and emotional actions (Strack & Millon, 2007).

Technical Evaluation

Reliability

The internal consistency of test scales denotes to how good the items measure the same concept. High internal consistency (for instance, coefficient $\alpha \geq .80$) is accepted for measures of stable personality characteristics to show the cohesiveness of the main traits. Lower points of internal consistency (for example, coefficient $\alpha \geq .70$) are adequate for research tools and measures of less stable traits in atypical populaces. MCM-I PD scales have in the past showed good levels of internal consistency, though two MCMI-III scales (Compulsive and Narcissistic) have shown less desired measures (coefficient $\alpha = .66$ and $.67$, in turn). As a whole, measurements for the scales have varied from ".73 to .95 for the MCMI-I Mdn = .82; .86 to .93 for the MCMI-II; Mdn = .90); and .66 to .89 for the MCMI-III Mdn=.84". The smallest internal consistency estimations for the MCMI-III came from two scales that evaluate several normal, healthy traits that are uncommonly observed in samples of psychiatric clients. The low support for the occurrence of items measuring normal, healthy traits in psychiatric samples is not surprising because most clients do not show their positive characteristics when looking for aid (Strack & Millon, 2007).

Test-retest reliability designates how consistent test scores are over a period. Personality scales are assumed to be consistent over lengthy periods of time amongst adult individuals due to the prevalent and fixed nature of the basic characteristics, thoughts, and behaviors. An assortment of studies that have utilized diverse client populaces and test-retest in-

Intervals vary between 5 days to 3 years have exhibited good stability for MCMI-II and MCMI-III PD scale scores. In studies on the MCMI-I, most have shown a test-retest interval of about 3 months and produced a median reliability coefficient for all scales of $r = .71$, with a vary between .19 (Passive-Aggressive) to .91 (Histrionic). Studies for the MCMI-II showed retest intervals between 21 days and 4 months (average was 2-3 months) and produced a median stability value of $r = .73$ for all scales, with a range of .62 (Borderline) to .78 (Compulsive). Lastly, for the MCMI-III, retest intervals between 5 days and 4 months have shown a median value across PD scales of $r = .78$, with a range of .58 (Depressive) to .93 (Strack & Millon, 2007).

Validity

MCMI PDs scales have done well as a group in regards to concurrent, convergent, and discriminant validity when calculated against other self-report scales of PDs. There have been steady increases in validity with every new form of the test and discovered the greatest concurrent validity amongst MCMI-III PD scales and the MMPI-2 PD scales. In one study, a sample of 477 clients and prisoners who finished a Dutch-language version of the MCMI-III, they discovered that the same PD scales across measures correlated between .56 (Narcissistic) and .75 (Borderline), with the exclusion of the MCMI-III Compulsive scale. It did not correlate positively with any of scales. One survey of the literature showed a relationship of weak concurrent, convergent, and discriminant validity for the scale between all forms of the MCMI, which shows that Millon's conceptualization of this disorder is dissimilar from that of other test designers (Strack & Millon, 2007).

All three forms of the MCMI have been proven to be helpful in making DSM diagnoses of PDs in mental health samples, even though results differ by scale. Research has proven that the MCMI is more diagnostically precise than clinical interviews and more precise than comparable self-report measures of personality but not more precise than structured interviews directed by experienced therapists (Strack & Millon, 2007).

Practical Evaluation

The qualification level to administer the MCMI-III test is a level C. The age range for the test is 18 years of age or older. Test takers must be at an 8th-grade reading level, which means for most adults they should be able to comprehend what they are reading (Millon Clinical Multiaxial Inventory-III Corrections Report, 2016).

The test can be taken with a paper and pencil, CD, computer or taken online. The test is generally short and will take 25 to 30 minutes to complete. Scoring and interpretation were done by an adult inmate correctional sample. The test can be scored by Q-global web-based, Q Local Software, manually, or by sending it in the mail (Millon Clinical Multiaxial Inventory-III Corrections Report, 2016).

Summary of Evaluation and Critique Strengths and Weaknesses

There are several strengths of the MCMI-III. One the main strengths of the MCMI-III is its brevity. It only takes about 30 minutes to complete (Charter & Lopez, 2002). Another

strength is that it is compatible with the Diagnostic and Statistical Manual of Mental Disorders (DSM). An added strength is that the MCMI-III is its theoretical foundation. As divergent to the other current clinical inventories, the selection of scales for the MCMI, and the association between the scales was done on a logical basis, subsequent to a fixed scheme. This was most beneficial when Millon's theory steered to the same charting of the DSM (Choca & Grossman, 2015).

Unfortunately, there are also several weaknesses of the MCMI-III. First is the circumstance that there is not an agreement amongst dimensional theorists regarding how many of traits are required to represent personality. Traditionally, theorist maintained that a single dimension would be sufficient. Then it went from three are needed, and some stated to have recognized as many as 33. Nevertheless, current models, most particularly the Five-factor model have started to attain a moderate level of agreement. And some proposed that the traits might equally be comprehended in a hierarchical fashion. However, issues are still evident in the research in regards to the quantity and which dimensions are required to cover normal and abnormal behavior and how to establish a practical hierarchy of higher order and lower order components and factors. Even though the etymological practice of utilizing personality terms fixed in common language has been beneficial in establishing a categorization of trait dimensions amongst normal individuals, the similar method has not been as effective in recognizing abnormal dimensional components (Strack & Millon, 2007).

Another weakness is the cumulative complexity of Millon's theory. Since most individuals have a distinctive personality, the quantity of categories that might be expressed is infinite, and all of these categories can be described as having a large amount of variances, incorporating a particular number of traits, and signifying specified levels of development or complexity. Possibly in "personology," as in numerous other areas of psychology, straightforward theories are best (Choca & Grossman, 2015).

Numerous suggestions are in development in regards to the development of the MCMI-IV. First, it was suggested that a separate profile sheet that could be produced as well as the standard profile page that would include Millon's most current abbreviations illustrating the personality spectra, in the place of the traditional descriptions (for example, EET in place of turbulent). This is allied with American Psychiatric Association developments and directions toward better openness in the evaluation, along with some methods reassurance of more straightforward and cooperative feedback in psychological analysis while circumventing the misleading of diagnostic labeling (for example, therapeutic assessment).

Carrie Millon (Millon's granddaughter) suggested a number of additions to the notable response categories (for example, markers for adult variations on cognitive disorders like attention deficit-hyperactivity disorder [ADHD]), that will be investigated more as information collection concludes. Lastly, as was Millon's aim, a better accent will be put on the therapeutic effectiveness by the use of an improved treatment guide connected more directly to the encouraging goals of the evolutionary theory, in addition to explanations of personality

dimensions in a reworked set of component scales (Choca & Grossman, 2015).

Future research should incorporate formulation of well-diagnosed disorder base rates connected with several junctions of “ m client traits, $m = 1, . . . , n$ ”. It is essential to classify base rates only for junctions of well-founded representative variables. The typical representative variable is gender, and its influence on the base rate of depression, for instance, is recognized. It interrelates with a birth cohort to effect the rate of major depression. However useful specific base rate representative variables might be, the examiner might often want to know the moderating impact of a junction of variables, which juncture is also detected in a specific client (Grove & Scott, 2009).

Future studies might also explore the efficacy exchange between the variability-produced error in local standardization of scale score distributions as opposed to the partiality intrinsic in local use of generally normed scales (as the MCMI-III currently covers; the normative population for each scale is presently considered to be nationally illustrative, not locally sampled). Researchers presented a cautious investigation of sampling error induced reduction of projecting validity in categorizing sex offenders as likely or unlikely recidivists. Even though these results highlight sampling error concerns, the researchers did not examine the influences of test bias when one nationally normed test scale allocation is utilized with a local populace whose true scale distribution is of dissimilar shape (Grove & Scott, 2009).

4 CONCLUSION

Although a conclusion may review the main points of the paper, do not replicate the abstract as the conclusion. A conclusion might elaborate on the importance of the work or suggest applications and extensions. Authors are strongly encouraged not to call out multiple figures or tables in the conclusion—these should be referenced in the body of the paper.

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